09330

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See Instructions on back of certificate.

V. S. No. 1.

1 PLACE OF DEATH

County Baltimore

Village or City Ft Washington (No. ____, ____ St.; ____ Ward)

2 FULL NAME Elmer David Abelmert

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6 DATE OF BIRTH February 15 (Month) (Day) 1891 (Year)

7 AGE 49 yrs. 6 mos. 13 ds. If LESS than 1 day, ____ hrs. OR ____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Lineman for Con. Gas & Electric Co
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore County

PARENTS

10 NAME OF FATHER Wm T. Abelmert

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret E Naylor

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Abelmert

(Address) Ft Washington Md

15 Filed Sept 29, 1940 M. Louella Van Horn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 28 (Month) (Day), 1940 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1940, to Sept 28, 1940, that I last saw h m alive on Sept 28, 1940, and that death occurred on the date stated above, at 12.16 P m.

The CAUSE OF DEATH * was as follows:

Cerebral Hemorrhage

(Duration) ____ yrs. ____ mos. 3 ds.

Contributory Secondary Arteriosclerosis

(Duration) 1 yrs. ____ mos. ____ ds.

(Signed) C. H. Beeton M. D.

8 28, 1940 (Address) Ft Washington Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Druid Ridge Cem | DATE OF BURIAL Oct 1, 1940

20 UNDERTAKER Philip Herwig & Son | ADDRESS 2024 Orleans St

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 7 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

09331

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH: Balto

County Essex

City or town

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto

City or town Dundalk Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1827 Kinship's Rd.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harry Atkins

3. (b) Social Security Number 213-09-2257

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marian Atkins

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): ? 1908

8. AGE: Years: 32 | Months: | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Walter H. Atkins
13. Birthplace: Va

MOTHER
14. Maiden name: Ella May Fegua
15. Birthplace: Va.

16. Informant: Mrs. Everett Atkins

Address: 15 Sollar Point Rd. (Dundalk)

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 18-1940 (month) (day) (year)

Cemetery or crematory: Balto. Nath. Cem.

Location: Catonsville Md.

18. Funeral director: John G. Connelly

Address: Essex, Md.

19. Sept. 18. — 1940 (Date rec'd by registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 15th 1940, at 2.35 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ~~____ 19____, to ____ 19____,~~ ~~and that I last saw h____ alive on ____ 19____.~~

Immediate cause of death: Auto accident.

Due to: Pedestrian, struck by

Due to: Auto on public highway

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: None

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~: Accident Date of: 9.15.40

Where did injury occur? Essex (City or town) Balto (County) Md (State)

Injured at home, farm, industry, public place (where?): Highway

Means of injury: Struck by Auto Injured at work? No

23. SIGNATURE: W. P. E. Nyse Leroy M. Tex M. D. or other

Address: Pikesville Md Date signed: 9.15.40

RECEIVED
SEP 19 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

09332

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County: Baltimore

City or town: Parkton P.O. (Mt. Carmel Road)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): Lifetime

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Parkton P.O. Mt. Carmel Rd. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. —
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Clarence Howard Bailey

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M.	White	Married

6 (b) Name of husband or wife: Bertie Cole Bailey

6(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): June 17, 1874

8. AGE:

Years	Months	Days	If less than one day
66	2	27	hrs. min.

9. Birthplace: Parkton P.O. (Mt. Carmel Rd.)
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: John W. Bailey
13. Birthplace: Parkton P.O. (Mt. Carmel Rd.)

MOTHER
14. Maiden name: Emma J. Hale
15. Birthplace: Parkton P.O. (Mt. Carmel Rd.)

16. Informant: Mrs. C. H. Bailey
Address: Parkton, Balto. Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 15, 1940 (month) (day) (year)

Cemetery or crematory: Mt. Carmel (Balto. Co.)

Location: Mt. Carmel, Balto. Co., Md.

18. Funeral director: Landon M. Brooks
Address: Sparks, Md.

19. Sept 13th 1940 (Date rec'd by registrar) Melvin Bortner, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 13 1940, at 3:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1937, to Sept. 13 1940 and that I last saw h 1 ly alive on Sept. 13 1940.

Immediate cause of death: Cerebral Thrombosis — DURATION: 9/8/40

Due to: generalized arteriosclerosis

Due to:

Other conditions: Chronic Myocarditis
(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: A. M. France, M. D. or other

Address: Parkton, Md. Date signed: 9/13/40

1940 67 1873

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

09333

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:
County: Balto.
City or town: Lineboro, Md RD #1
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 85-10-20

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Lineboro Md. #1 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: ELIAS BAILEY

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of ~~husband or~~ wife: Mary Hoffman Bailey
6(c) If alive, give age: 79 years
7. Birth date of deceased (mo., day, yr.): Oct. 17. 1854

8. AGE: Years: 85 Months: 10 Days: 20 If less than one day: hrs. min.

9. Birthplace: Balto. Co. Md
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business
FATHER
12. Name: Fred Bailey
13. Birthplace: Md.
MOTHER
14. Maiden name: Anna Zimmerman
15. Birthplace: Md
16. Informant: C H Bailey
Address: Lineboro, Md RD #1
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 10. 1940 (month) (day) (year)
Cemetery or crematory: Stelzis
Location: Glen Rock, Pa R.D.
18. Funeral director: Geo. Geiple and Son
Address: Glen Rock, Pa
19. Sept 7th 1940 (Date rec'd by registrar) Chester L Fulton Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 7 1940, at 10.40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1940 to Sept 7 1940, and that I last saw him alive on Sept 5 1940.

Immediate cause of death: Chr. Myocarditis — DURATION: 6 yr.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Paul D Hart Md
M. D. or other
Address: Shrewsbury Pa Date signed: 9-7-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 4 1940
BUREAU V. S.

09334

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH

County: Baltimore

City or town: (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Pimlico Rd - Nr Smith Ave

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Balto Co.

City or town: — Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Pimlico Rd. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Amelia H. Bayhan

3. (b) Social Security Number: None

4. Sex: F

5. Color or race: W.

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Oscar W.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 16 - 1880

8. AGE: Years: 60 Months: 1 Days: 29 If less than one day: hrs. min.

9. Birthplace: Baltimore City Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Self.

FATHER
12. Name: John H. Jenkins
13. Birthplace: Baltimore

MOTHER
14. Maiden name: Mary Hicks
15. Birthplace: Baltimore

16. Informant: Mary A. Warner

Address: Pimlico Rd - Nr Smith Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sep 18 - 40 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cem.

Location: ~~Balto~~ A.A. Co.

18. Funeral director: William Cook

Address: 1217 St Paul St

19. Sep 16 - 1940 (Date rec'd by registrar) E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 15 - 1940, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug - 3 1940, to Sep 15 1940, and that I last saw her alive on Sep 15 1940.

Immediate cause of death: Cardiac dilatation

Due to: Valvular heart disease

Due to: Old rheumatic heart disease

Other conditions: Cerebral embolism

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION: 5 / 1 / 1 yr

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Samuel H Cuenca M.D. or other

Address: 5611 Pimlico Rd. Date signed: Sep 16-40

VS A15 (I) (T) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 18 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (94a) Reg. Dist. No. 47 09335

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Middle River (Rural)
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Bird River Road.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 60 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Middle River (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bird River Rd.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** John Michael Bevans.

3 (b) If veteran, name war

3 (c) Social Security No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife Annie Bevans

6. (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) April 19 1873

8. AGE: Years 67 | Months 5 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace Middle River. Balt. Co. Md.
(Town, county, and state)

10. Usual occupation Farmer.

11. Industry or business Own Farm.

FATHER
12. Name John Bevans
13. Birthplace Middle River. Balt. Co. Md.

MOTHER
14. Maiden Name Mary Nolan.
15. Birthplace Ireland.

16 (a) Informant Mrs. J. M. Bevans
(b) Address Middle River Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20th 1940 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 (a) Sept 20-40 (Date rec'd by registrar) (b) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. Date of death Sept. 19 1940, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1940, to Sept 19 1940, and that I last saw him alive on Sept 17 1940.

Immediate cause of death	Duration
Coronary thrombosis	4 mo.
Due to Hypertensive arteriosclerotic cardio vascular disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard S. Owens M.D. (M. D. or other)
Address Raspeburg, Md. Date signed Sept. 19, 1940

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

09336

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Ellicott City, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Westchester Ave

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Ellicott City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Westchester Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Esther Burgee

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widow

B (b) Name of husband or wife: Robert H. Burgee

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 10, 1853

8. AGE:

Years	Months	Days	If less than one day
87	11	23	____ hrs. ____ min.

9. Birthplace: Tridelphia Howard Co. Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Retired

FATHER
12. Name: Ephram Harn
13. Birthplace: Carroll Co. Md.

MOTHER
14. Maiden name: Elizabeth Gosnell
15. Birthplace: Carroll Co., Md.

16. Informant: Mrs E. T. Burgee
Address: Ellicott City, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 6, 1940 (month) (day) (year)

Cemetery or crematory: Della Cemetery

Location: Della Md.

18. Funeral director: Easton Sons,
Address: Ellicott City, Md.

19. 9/6/40 (Date rec'd by registrar) 19 [signature] Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 3, 1940, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 19__, to Sept 3 1940, and that I last saw her alive on Sept 3 1940.

Immediate cause of death: Chronic Myo-Carditis, Acute Dilatation

DURATION: ?

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Cate of:

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank E. O. Miller M. D. or other

Address: Ellicott City Md. Date signed: Sept 5

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 1 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (S) Reg. Dist. No. 44 09337

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Balto
(b) City or town Fort Howard (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Todd ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in this community (yrs., mos., or days) —

USUAL RESIDENCE (USUAL RESIDENCE) OF DECEASED:
(a) State md (b) County Balto
(c) City or town Ft. Howard (If outside city or town limits, write RURAL and give town)
(d) Street No. Todd ave (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Donna Kay Burnham

3 (b) If veteran, name war —
3 (c) Social Security No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 27. 1940

8. AGE: Years born dead | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Fort Howard. (Town, county, and state)

10. Usual occupation none

11. Industry or business none

FATHER
12. Name Frank Anthony Burnham
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Dorothy V. Trembly
15. Birthplace Albright. W. Va

16 (a) Informant Dorothy Burnham
(b) Address as above

17 (a) Baltimore (Burial, cremation, or removal) (b) Date thereof 9/27/40 (month) (day) (year)
(c) Cemetery or crematory —
Location Johns Hopkins Hosp. Biological Labs

18 (a) Funeral director —
(b) Address —

19 (a) Sept 28-40 (Date rec'd by registrar) (b) Dawson L. Harbert Dep. Registrar

MEDICAL CERTIFICATION

20. Date of death Sept 27 1940, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1940, to Sept 27 1940, and that I last saw him alive on Sept 27 1940.

Immediate cause of death	Duration
Still birth —	
Due to Premature birth (5 months)	
Due to	
Other conditions none —	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Louis N. Tallue M.D. (M. D. or other)
Address Sparrows Point md Date signed 9/27/40

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-a)

09338

38

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VSA15

1. PLACE OF DEATH

County: Baltimore

City or town: Riderwood

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant give residence of mother)

State: Maryland County: Baltimore

City or town: Riderwood Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Sarah Ann Byers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Married

8 (b) Name of husband or wife: George W. Byers

6(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): 3 10 1863

8. AGE: Years	Months	Days	If less than one day
77	6	10	hrs. min.

9. Birthplace: Hanover, Pa. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER 12. Name: George Roller

FATHER 13. Birthplace: Pennsylvania

MOTHER 14. Maiden name: Elizabeth Silly

MOTHER 15. Birthplace: Manchester, Md.

16. Informant: Geo. W. Byers

Address: Riderwood, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9-22-40 (month) (day) (year)

Cemetery or crematory: Briders Cem.

Location: Near Westminster, Md

18. Funeral director: H. Bankard & Son

Address: Westminster, Md.

19. 9/21/40 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 20 1940 at 4:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31 1940 to Sept 20 1940, and that I last saw her alive on Sept 19, 1940.

	DURATION
Immediate cause of death: Intestinal obstruction, strangulated hernia, ventral abdominal.	12 hrs
Due to: Hernia, ventral abdominal, in postoperative recipient sear.	40 yrs
Due to: Uterine fibroid tumor	40 yrs
Other conditions: Senile dementia Arteriosclerosis, advanced. (Include pregnancy within 3 months of death)	4 yrs Unkn.

Major findings:

Of operations: None

Of autopsy: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Rollin E. Hudson M.D. M. D. or other

Address: Towson, Md. Date signed: 9/20/40

RECEIVED
OCT 7 1940
BUREAU V. S.

~~Duplicate~~

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Relay, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:
Relay Sanitarium, Relay, Md.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State 4317 Groveland Avenue, County Baltimore, Md.

City or town .....
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Clifford, James A.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Minna P. Clifford

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10-26-1865

8. AGE: Years	Months	Days	If less than one day
74	10	17	..... hrs. ..... min.

9. Birthplace New York
(Town, county, and state)

10. Usual occupation Retired from General Electric Co.

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden name
15. Birthplace unknown

16. Informant Daughter- Mrs. John Jenkins

Address 3315 Liberty Heights Avenue, Baltimore Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/14/40 (month) (day) (year)

Cemetery or crematory Woodlawn

Location Baltimore Co.

18. Funeral director Wm. Cook

Address 1217 St. Paul St.

January 13 1932 (Date rec'd by Registrar) 19 .....

Geo. Kieffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1940 19 ..... at 8:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....

and that I last saw h ..... alive on ..... 19 .....

Immediate cause of death	DURATION
Cardio-Vascular Disease	
Coronary Thrombosis	
Due to Sudden death	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Louis P. Gundry M.D.
M. D. or other

Address Relay, Md. Date signed .....

Authorization for addition - phone call Wm. Cook by L.L. 1-12-42

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09339

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs + 2 mos.

Hospital, institution, or street address where death occurred: Spring Grove State Hospl.

How long in hospital or institution? 2 yrs + 2 Mos

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3018 W. Garrison Ave

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME Mr. Abraham Cohen

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife NONE

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-15-1893

8. AGE: Years	Months	Days	If less than one day
47	4	22	..... hrs. ..... min.

9. Birthplace Poland (Town, county, and state)

10. Usual occupation push cart peddler

11. Industry or business Self -

FATHER 12. Name Samuel Cohen

13. Birthplace Poland

MOTHER 14. Maiden name Millie Hoffman

15. Birthplace Poland

16. Informant Relative S. H. State Hospl

Address Catonsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 6-1940 (month) (day) (year)

Cemetery or crematory Hebrew Rosedale

Location Hamilton Ave & Philadelphia Rd

18. Funeral director Jack Lewis & Son

Address 1439 E. Baltimore St

19. 9/6/40 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6, 1940, at 8:55 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-25-1940, to 8-6-1940 and that I last saw h[illegible]alive on 8-3-1940

Immediate cause of death	DURATION
1. Acute Pulmonary Tuberculosis,	
Due to Bilateral,	
Due to	
Other conditions Mental deficiency with psychosis	

(Include pregnancy within 3 months of death)

Major findings of operations NONE

Date of op. NONE

Autopsy results ?

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert E. Gardner 40 M. D. or other

Address ..... Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 1 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 30 99340

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Galatian Sau Edmondson & Ingleside Aves

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 2566 W. Baltimore St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No.

3. (a) FULL NAME: Anna Croggon - CROGGON

3. (b) Social Security Number: No

4. Sex: Female

5. Color or race: white

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Thomas J. Croggon

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 25 - 1873.

8. AGE: Years: 67 Months: 3 Days: 4 If less than one day: — hrs. — min.

9. Birthplace: Baltimore City (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home

FATHER

12. Name: John Schafer

13. Birthplace: Germany

MOTHER

14. Maiden name: Unknown

15. Birthplace: Germany

16. Informant: Mrs. A. F. Hartung

Address: 3120 Cliftmont Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 1-40 (month) (day) (year)

Cemetery or crematory: Western Cemetery

Location: Baltimore City

18. Funeral director: F. B. Wippert & Son

Address: ~~9-30-40~~ 1300 Eastern Ave

19. 9-30 1940 H. C. Andrew (Date rec'd by registrar) Registrar

DEPUTY LOCAL

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 29 - 1940, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 9, 1935, to Sept 29, 1940, and that I last saw her alive on Sept 29, 1940.

Immediate cause of death: Generalized Carcinomatosis

Due to: Carcinoma of breast

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: Carcinoma of breast.

Of autopsy:

DURATION: 1937

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George A. Knipp M.D. (M.D. or other)

Address: 3030 Edmondson Ave. Date signed: 9.30.40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M) (I)

RECEIVED
NOV 1 1940
M. BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

09341

Reg. Dist. No. 4-2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Relay
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Rolling Road.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 13 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ↓ County ↓
City or town ↓ Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. ↓
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR none

3. (a) FULL NAME Mary Stuart Crosby

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Harvey M. Crosby
6(c) If alive, give age ↓ years

7. Birth date of deceased (mo., day, yr.) Nov 23 1858

8. AGE: Years	Months	Days	If less than one day
81	10	0	hrs. min.

9. Birthplace Abingdon Va.
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business

FATHER
12. Name William Deady
13. Birthplace unknown

MOTHER
14. Maiden name Elizabeth Scott
15. Birthplace unknown

18. Informant Mrs Dorothy L. Thurston
Address Relay Md

17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof 9/24/40 (month) (day) (year)
Cemetery or crematory
Location Abingdon, Virginia

18. Funeral director Wm. J. Tickner & Sons,
Address North & Pa. Avenues

19. September 23-40 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1940 at 9 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1939, to Sept 23 1940,
and that I last saw on alive on Sept 23 1940.

Immediate cause of death	DURATION
(a) Chr. Myocarditis	1 yr.
Due to (b) Chronic Infections Arthritis & Pyorrhea	10 yr.
Due to (c) Chr. Bronchitis Arterial Hypertension	1 yr.
Other conditions Senility General Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B B Brumbaugh M. D. or other
Address Elkridge Md Date signed 9/23/40

RECEIVED
SEP 28 1940
BUREAU V R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

09342

Reg. Dist. No. 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Freeland Md near Ruhls
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Ruhl near Freeland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Geraldine P. Day

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): April 2 1921

8. AGE: Years	Months	Days	If less than one day
19	5	9	hrs. ____ min.

9. Birthplace: Green Spring Valley, Md. (town, county, or state)
10. Usual occupation: Maid
11. Industry or business: Home
FATHER 12. Name: William Day
13. Birthplace: Parkton Md. R D
MOTHER 14. Maiden name: Rattie Mixter
15. Birthplace: Ruhls Md.
16. Informant: William Day
Address: Freeland, Md. R.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 14, 1940 (month) (day) (year)
Cemetery or crematory: Mt. Zion.
Location: Freeland, Md.
19. Funeral director: Jacob Bartenstein
Address: New Freedom, Pa.
19. Sept. 13 1940 (Date rec'd by registrar) Samuel R. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11 1940 at 9:10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 1940 to Sept 11 1940 and that I last saw h[illegible] alive on Sept 10th 1940

Immediate cause of death	DURATION
Coronary Throm bosis	1 day
Due to Acute Septic Cardiitis	
Due to Acute Multiple arthritis (Streptococcus)	
Other conditions Streptococcus infection	

(Include pregnancy within 3 months of death)

Major findings: none
Dt operations
Dt autopsy none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Cole Boyer M. D. or other
Address: New Freedom, Pa. Date signed 9/12/40

RECEIVED
OCT 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

09343

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Ellicott City (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Ellicott City (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Linwood Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Phillips Deitz, Sr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Married

6.(b) Name of husband or wife Margaret Deitz
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1871

8. AGE: Years	Months	Days	If less than one day
68	8	28	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name John Deitz
13. Birthplace Germany

MOTHER
14. Maiden name unknown
15. Birthplace

16. Informant Mrs. Margaret Deitz
Address Ellicott City Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-20-40 (month) (day) (year)
Cemetery or crematory Old Salem Lutheran
Location Catonsville Md.
18. Funeral director H. Higinbotham Jr.
Address Ellicott City Md.
19. 9/18 19 40 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 19 40 at 5P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 40 to Sept 17 19 40
and that I last saw h.. l.. alive on 9-17 19 40

Immediate cause of death	DURATION
Rheumatic Cardio-Vascular Disease	5 years
Due to	
Due to	
Other conditions Hypertension	2 years

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George E. Bugtap M.D.
M. D. or other
Address Ellicott City Date signed 9-18-40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 1 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

09344

CERTIFICATE OF DEATH

Reg. Dist. No. 30

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (I) MARGIN RESERVED FOR BINDING (M)

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs - 6 mo - 2 das

Hospital, institution, or street address where death occurred: Spring Grove State Hospt

How long in hospital or institution? 15 yrs - 6 mo - 2 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Catonsville, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 902 Eastern Ave

(If rural, give LOCATION)

2.(a) If veteran, name war NO

3.(a) FULL NAME Mrs Clara De Arge

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married.

6.(b) Name of husband or wife ?

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
About 65 yrs			..... hrs. ..... min.

9. Birthplace Italy (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name ?

13. Birthplace Italy

MOTHER 14. Maiden name Clara Fastera

15. Birthplace Italy

16. Informant Records U. S. G. S. Hospt.

Address Catonsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 30 1940 (month) (day) (year)

Cemetery or crematory Holy Redeemer Cemetery

Location Belair Road

18. Funeral director John A. Grebliauckas, Jr

Address 423 S. Paca St.

19. 9-30 (Date rec'd by registrar) 19 40 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28- 1940, at 4 53 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-20- 1940 to 9-28- 1940 and that I last saw h.. alive on 9-27- 1940

	DURATION
Immediate cause of death 1. Cerebral Hemorrhage	9 days
Due to Hypertension & Chronic myocarditis	6 yrs 2-5 yrs
Due to Arterio Sclerosis (generalized)	2-6 yrs
Other conditions Dementia praecox	15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations NO

Date of op.

Autopsy results NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert E. Gardner M.D.

M. D. or other

Address Date signed

DEPUTY LOCAL

RECEIVED
OCT 1 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-0)

09345

31

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto

City or town Stemmers Run

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town ~~Stemmers Run~~ Balto. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 510 N. Glover

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR no.

3. (a) FULL NAME JOHN DIEHL JOHN JOSEPH DIEHL

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Clara Diehl

B (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1st

8. AGE: Years 75. Months Days If less than one day hrs. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation Tailor

11. Industry or business Self Employed

FATHER 12. Name unknown

13. Birthplace "

MOTHER 14. Maiden name "

15. Birthplace "

16. Informant Mrs Catherine Zehner

Address 510 N. Glover St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 4, 1940 (month) (day) (year)

Cemetery or crematory Baltimore

Location north + Montford

18. Funeral director John C. Miller Inc.

Address 2435 E. Olivia St.

19. Sept 1st 1940 (Date rec'd by registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1940, at P. M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ ~~19 to 19~~

~~and that I last saw h alive on 19~~

Immediate cause of death

Accident, Auto on highway, Philadelphia Road

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~ Date of 8-31-40

Where did injury occur? Stemmers Run (City or town) Balto (County) Md (State)

Injured ~~at home, farm, industry~~ public place (where?) highway

Means of injury struck by auto Injured at work? no

23. SIGNATURE W. P. O. Mrse Leipsy M Ex M. D. or other

Address Pikesville Md Date signed 9-1-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 13 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 33

09345

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Owings Mills (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Reisterstown Road
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Owings Mills (If outside city or town limits, write RURAL and give town)
(d) Street No. Reisterstown Road (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Alethia Digges

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William M. Digges

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb 14 - 1873

8. AGE: Years 67 | Months 7 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Randallstown, Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Thomas C. Shipley
13. Birthplace Randallstown, Md.

MOTHER
14. Maiden Name A. Marcella Cross
15. Birthplace Randallstown, Md.

16 (a) Informant Mr. Otis Shipley
(b) Address Liberty Road, Randallstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 24, 1940 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director [illegible]
(b) Address 1003 W. Baltimore St.

19 (a) Sept 21 1940 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. Date of death September 21st 1940, at 9:10 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 1937, to 9/21/1940, and that I last saw him alive on 9/21/1940.

Immediate cause of death	Duration
Pulmonary Tuberculosis	25 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James L. Shipley M. D. or other
Address Reisterstown Md. Date signed 9/24/40

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 1 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09347

CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 408 Oak Ave
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Colgate Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 408 Oak Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No

3.(a) FULL NAME: William F. Dorn Jr.

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 23 - 1931

8. AGE: Years	Months	Days	If less than one day
9	1	0	hrs. min.

9. Birthplace: Baltimore Co.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: William F. Dorn
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden name: Gresse Long
15. Birthplace: Baltimore Co.

16. Informant: William F. Dorn (Father)
Address: 408 Oak Ave

17. Burial (Burial, cremation or removal. Which?) Date thereof: Sept 24-1940 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Eastern Ave Road

18. Funeral director: Lilly & Leiler INC.
Address: 403 S. Wolfe St.

19. Sept. 24 1940 (Date rec'd by registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 23 1940 at 9:45 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 9 1940 to Sept 23 1940 and that I last saw him alive on Sept 23 1940

Immediate cause of death	DURATION
Tuberculosis Pertinax	9-9-40
Due to Interstitial Bronchopneumonia	9-20-40
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: None.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: none. Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Ed Schumuck Jr. M. D. or other
Address: 842 S. Eastern Ave Date signed: 9-27-40

RECEIVED
OCT 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-b)

09348

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Baltimore

City or town: Reisterstown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, institution, or street address where death occurred: Mount Pleasant

How long in hospital or institution? 5 months

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 820 East Preston St (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Endres

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Jerome Endres

6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): December 31, 1918

8. AGE:

Years	Months	Days	If less than one day
21	8	~~24~~ 7	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: James George Durkin
13. Birthplace: U.S.A.

MOTHER
14. Maiden name: Minerva Strausheim
15. Birthplace: U.S.A.

16. Informant: Deceased

Address: same

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 11 1940 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Old Frederick Road Balto

18. Funeral director: George J. Rutto Inc.

Address: 1735 Harford Ave

19. Sept 8 1940 (Date rec'd by registrar) J. Dunfield Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 1940, at 9.55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 1940, to Sept. 7 1940 and that I last saw her alive on Sept. 7 1940

Immediate cause of death	DURATION
Chronic Pulmonary Tuberculosis	unknown
Due to	
Due to	
Other conditions: Laryngeal Tuberculosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Samuel Lipstein M.D. M. D. or other

Address: Mt. Pleasant Reisterstown, Md Date signed: Sept. 7, 1940

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 12 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

09349

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County Balto
City or town Dundalk
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Dundalk Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 151 Wise ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME Franklin F. Finkeldey

3. (b) Social Security Number none

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced widower

B (b) Name of husband or wife Catherine Bolander

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1870

8. AGE: Years 69 Months 9 Days 9 If less than one day hrs. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation Sheet Metal Worker
11. Industry or business Retired
FATHER 12. Name Finkeldey
13. Birthplace Germany
MOTHER 14. Maiden name
15. Birthplace Germany
16. Informant Mrs. Edith Webster
Address 151 Wise ave, Dundalk, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 16, 1940 (month) (day) (year)
Cemetery or crematory Baltimore, Md.
Location Baltimore, Md.
18. Funeral director A. Howard Evans
Address 1400 S. Charles St.
19. Sept. 13 1940 (Date rec'd by registrar) W. M. Cummins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1940, at 6-10 PM

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ~~19~~, to ~~19~~, ~~and that I last saw h~~ alive on ~~19~~

Immediate cause of death Valvular heart disease — DURATION ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. P. O. Nyse Lefty M Rex M.D. or other
Address Pikesville Md Date signed 9-13-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 21 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

09350

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: BALTIMORE.

City or town: Reisterstown, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 147 Main St. Reisterstown

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 77 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Reisterstown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 147 Main Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Thomas Jefferson Davis Fisher.

3. (b) Social Security Number:

4. Sex: Male. 5. Color or race: White. 6. (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Kate Cora Fisher.

6(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): JAN. 18 1863.

8. AGE: Years: 77 Months: 8 Days: 12 If less than one day: ___ hrs. ___ min.

9. Birthplace: Reisterstown, Md.
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business: Painter worked for himself

FATHER
12. Name: John Fisher
13. Birthplace: Reisterstown, Md

MOTHER
14. Maiden name: Mary Mackelfresh.
15. Birthplace: Reisterstown, Md.

16. Informant: James Oscar Fisher
Address: Reisterstown, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Oct. 2, 1940 (month) (day) (year)

Cemetery or ~~crematory~~: Cemetery

Location: Luthern Cemetery Reisterstown

18. Funeral director: Wm. Berryman & Sons.
Address: Reisterstown, Md.

19. Oct. 1 1940 (Date rec'd by registrar) J. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/30/1940, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/1/1940, to 9/30/1940, and that I last saw h IM alive on 9/29/1940.

	DURATION
Immediate cause of death: Uremic coma	3 days
Due to: Chronic nephritis	2 yrs
Due to: Hypertension	5 yrs
Arteriosclerosis	5 yrs
Other conditions: Chronic Prostatitis	1 yr

(Include pregnancy within 3 months of death)

Major findings:
Of operations: ✓
Of autopsy: ✓

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: James G. Saffell M. D. or other
Address: Reisterstown, Md Date signed: 10/1/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (97) Reg. Dist. No. 38

CERTIFICATE OF DEATH

09351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING VS. A15

1. PLACE OF DEATH:

(a) County BALTIMORE

(b) City or town TOWSON R.F.D. #6 (RURAL)
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: OLD HARFORD ROAD

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 5 YRS.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State MD. (b) County BALTIMORE

(c) City or town TOWSON R.F.D. #6 (RURAL)
(If outside city or town limits, write RURAL and give town)

(d) Street No. OLD HARFORD ROAD
(If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** LAURA FOARD

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife CHARLES E. FOARD

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) APRIL 9, 1853

8. AGE: Years 87 | Months 4 | Days 28 | If less than one day _____ hr. _____ min.

9. Birthplace BALTO. CO., MARYLAND
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business AT HOME

FATHER
12. Name — McCOBBIN
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant MELVIN GEESEY

(b) Address OLD HARFORD RD. TOWSON R.F.D. #6

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 10, 1940 (month) (day) (year)

(c) Cemetery or crematory DRUID RIDGE

Location PIKESVILLE, MD.

18 (a) Funeral director John Burns' Sons

(b) Address Towson, Md.

19 (a) Sept 9 1940 (Date rec'd by Registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. Date of death SEPT. 6, 1940, at 10:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1939, to Sept 6 1940, and that I last saw him alive on Sept 6 1940

Immediate cause of death	Myocarditis chronic	Duration
Due to	Senility	
Due to		
Other conditions	Gen. arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence —

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury —

23. Signature Victor Richards
M. D. or other

Address 7301 York Rd Date signed Sept-7-'40

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

09352

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Notch Cliff near Towson (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Villa Maria

Stay in hospital or inst. (yrs., or mos., or days): 1 yr.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Baltimore Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 901 Kisquith St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Sister Mary Aloyse Foige

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 3 - 1867

8. AGE: Years	Months	Days	If less than one day
73	1	12	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Teacher

11. Industry or business:

FATHER
12. Name: Henry Foige
13. Birthplace: Hamburg, Germany

MOTHER
14. Maiden name: Joan Wright
15. Birthplace: Harford Co., Md.

16. Informant: Sr. Mary Clara

Address: Glenarm P.O. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 17/40 (month) (day) (year)

Cemetery or crematory: Notch Cliff, Provo.

Location: Green Ave

18. Funeral director: Geo M. Fritz Son

Address: 811 N Wolfe St

19. 9-16 1940 (Date rec'd by registrar) W M Hammett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 15 1940, at 8.40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1940, to Sept. 15 1940, and that I last saw her alive on Sept. 4/40 1940.

Immediate cause of death: Carcinoma (breast) — DURATION: 3 yrs.

Due to:

Due to:

Other conditions: General Carcinoma

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
OCT 3 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-B

CERTIFICATE OF DEATH

Not BC

09353

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years, 11 months.

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 11 years and 11 months.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 2 Winthrop Avenue (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary A. Fryer

3.(b) Social Security Number: NONE

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 9, 1864

8. AGE: Years 76 | Months 1 | Days 16 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Frank A. Coxon
13. Birthplace: England

MOTHER
14. Maiden name: Jennie Halloway
15. Birthplace: England

18. Informant: Hospital Records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 27 '40 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Frederick Rd

18. Funeral director: William Cook

Address: 1217 St Paul St

19. 9/25 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 25, 1940, at 1:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19, 1936, to September 25 1940 and that I last saw her alive on September 25, 1940

Immediate cause of death	DURATION
Carcinoma of the uterus	4 years
Chronic myocarditis	1 year
Cystic degeneration of kidneys bilateral before	1940
Other conditions: Cerebral arteriosclerosis before	1928

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: As given above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Serge Androp, M.D. M. D. or other

Address: Spring Grove St. Hosp. Date signed: 9-25-40

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OCT 1 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

09354

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County Balto.
City or town Glyndon (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Balto.
City or town Glyndon (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Margaret E. Fuss

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Albert W. Fuss
6.(c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) June 19, 1860

8. AGE: Years	Months	Days	If less than one day
80	2	22	hrs. min.

9. Birthplace Carroll Co. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Peter Woods
13. Birthplace Carroll Co.
MOTHER 14. Maiden name Mary Bush
15. Birthplace Carroll Co.
16. Informant Albert W. Fuss
Address Glyndon, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 12, 1940 (month) (day) (year)
Cemetery or crematory Druid Ridge
Location Balto. Co.
18. Funeral director J. F. Eline & Sons
Address Reisterstown, Md.
19. Sept. 11 1940 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1940, at 10A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-4-' 1938, to 9-10 1940 and that I last saw her alive on 9-10 1940.

Immediate cause of death	DURATION
Coronary Occlusion	10 min.
Due to arteriosclerosis	5 yrs.
Due to	
Other conditions Hypertension	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. D. Taylor, M.D. M. D. or other
Address Reisterstown, Md. Date signed 9-10-'40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 2 1940
[illegible] U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 131-E Reg. Dist. No. 2

CERTIFICATE OF DEATH

09355

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Woodlawn (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Windsor Mill Road
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 50 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Woodlawn (If outside city or town limits, write RURAL and give town)
(d) Street No. Windsor Mill Road (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** CATHERINE ELIZABETH GARRIOTT

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles P. Garriott

6. (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Jan. 3rd. 1871

8. AGE: Years 69 | Months 8 | Days 12 | If less than one day ____hr. ____min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER
12. Name Frederick Heckner
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Charles P. Garriott
(b) Address Woodlawn, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18"1940 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive
Location Randallstown, Maryland

18 (a) Funeral director J. H. Armacost
(b) Address 1008 West Baltimore St.

19 (a) Sept 15 1940 (Date rec'd by registrar) (b) Henry A. Owings Registrar

MEDICAL CERTIFICATION

20. Date of death Sept. 15th 1940 19___, at 9.40 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12 1934 to Sept. 15 1940, and that I last saw her alive on Sept 14 1940.

Immediate cause of death	Duration
Chronic Myocardial Degeneration	5 yrs.
Due to	
Due to	
Other conditions Arterial Hypertension 6 yrs Chronic Nephritis 4 yrs	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy Not done

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joshua H. Armacost M.D. (M. D. or other)
Address Woodlawn, Md Date signed Sept 16 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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OCT 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-D)

09356

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Baltimore

City or town Owings Mills
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Gwynnbrook Ave

Stay in hospital or inst. (yrs., or mos., or days) ✓

Stay in this community (yrs., or mos., or days) 6 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Owings Mills Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Gwynnbrook Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME Joseph Jason Goodrich

3. (b) Social Security Number none

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

B (b) Name of husband or wife Eva Pearl Goodrich

6(c) If alive, give age 29 years

T. Birth date of deceased (mo., day, yr.) June 8 - 1905

8. AGE: Years 35 | Months 2 | Days 26 | If less than one day ____ hrs. ____ min.

9. Birthplace Royal Center - Cass - Indiana
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business —

FATHER
12. Name Hiram Edgar Goodrich
13. Birthplace Royal Center, Indiana

MOTHER
14. Maiden name E. Maud St Clair
15. Birthplace Cass County, Indiana

16. Informant Mrs. Eva P. Goodrich

Address Owings Mills

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Sept - 7 - 1940
(month) (day) (year)

Cemetery or crematory Cline Cemetery

Location Royal Center, Ind.

18. Funeral director Wm. Berryman & Sons

Address Reisterstown Md

19. Sept 4 - 1940 (Date rec'd by registrar) J. Frank Mitchell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1940, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st 1940, to Sept 4 1940, and that I last saw him alive on Sept. 4 1940.

Immediate cause of death Carcinoma of the jaw

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Frank Mitchell M.D. or other

Address Reisterstown Date signed

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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OCT 2 1940
... V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

09357

Reg. Dist. No. 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Kingsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Belair Road
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Kingsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Belair Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Marie R. Green

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife: --

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 4, 1886

8. AGE:

Years	Months	Days	If less than one day
53	10	25	hrs. min.

9. Birthplace: Balto. Co., Md.
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business:

FATHER
12. Name: Chas. H. Green
13. Birthplace: Balto. Co., Md.

MOTHER
14. Maiden name: Amelia Seidel
15. Birthplace: Balto. Co., Md.

16. Informant: Miss Irene Green,
Address: Kingsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 2, 1940 (month) (day) (year)
Cemetery or crematory: Blenheim Lutheran Cemetery
Location: Balto. Co., Md.

18. Funeral director: Lansdale Funeral Home
Address: 7401 Belair Road

19. 9-30-40 (Date rec'd by registrar) 19 W. M. Hammett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 29 1940, at 11.45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1935, to date 19; and that I last saw h alive on Sept 29 1940.

Immediate cause of death	DURATION
Pulmonary Edema	2 days
Due to Carcinoma of lung & pleura (Right side)	1 yr
Due to Carcinoma of Right breast	13 yrs
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Carcinoma of breast with metastasis to chest
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE: Harry P. Shelley M.D.
M. D. or other
Address: 8 E Madison st Date signed 9/29/40

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OCT 3 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

09358

(61)

1. PLACE OF DEATH

County Balto Registration Dist. No. 38

Village or City 1 Mile North of Towson No. Greenridge Road St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Elizabeth Margaret Haupt If U. S. Veteran, specify WAR

(a) Residence: No. Greenridge Road St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~ (write the word): Married

5a. If married, ~~widowed, or divorced~~ HUSBAND ~~of~~ (or) WIFE of William F. Haupt

6. DATE OF BIRTH (month, day, and year) Nov 4th 1868

7. AGE: Years 71 | Months 10 | Days 6 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. At Home

10. Date deceased last worked at this occupation (month and year) X

11. Total time (years) spent in this occupation X

12. BIRTHPLACE (city or town) (State or country) West Virginia

FATHER

13. NAME Edward Favorite

14. BIRTHPLACE (city or town) (State or country) Frederick Co. Md.

MOTHER

15. MAIDEN NAME Elizabeth Belmyre

16. BIRTHPLACE (city or town) (State or country) West Virginia

17. INFORMANT (Address) Edward F. Haupt Greenridge Rd above Towson Md

18. BURIAL, ~~CREMATION, OR REMOVAL~~ Place Mt Maria Towson Date 9/13 1940

19. UNDERTAKER (Address) William C. Cook 1217 St Paul St.

20. FILED 9/11, 1940 W. Carroll Van Horn Deputy Vocal Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Sept (Month) 10 (Day), 1940 (Year)

22. I HEREBY CERTIFY That I attended deceased from Sept 10 1940 to Sept 10, 1940

I last saw her alive on Sept 10, 1940; death is said to have occurred on the date stated above, at 8.15 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	9-10-40.
Hypertension	unk.
Nephritis, Chronic	unk.

Other Contributory Causes of Importance:

Diabetes Mellitus	1938
Cerebral arteriosclerosis	unk.

Name of operation none Date of —

What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Bennett A. Stoen M. D.

(Address) Lutherville, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 3, 1923*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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BUREAU V.S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

09359

CERTIFICATE OF DEATH

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T)

1. PLACE OF DEATH:

County: Pikesville Md.

City or town: (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Pikesville Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 100 Old Court Rd.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Fabious H. Hayes

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Nellie Hayes

6(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Feb. 19- 1871

8. AGE:

Years	Months	Days	If less than one day
69	7	5	hrs. ___ min.

9. Birthplace: Raleigh N. C.
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Retired

FATHER
12. Name: Bill Hayes
13. Birthplace: N. Carolina

MOTHER
14. Maiden name: Hattie Jackson
15. Birthplace: N. Carolina

16. Informant: Mrs. Nellie Hayes

Address: 100 Old Court Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 27- 40 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Reisterstown Road.

18. Funeral director: John H. Valentine

Address: 2326 Aiken St.

19. 9/25 1940 E. E. Nichols
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 24th 1940, at 11:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1938 to Sept 24 1940, and that I last saw him alive on Sept 24, 1940 1940.

	DURATION
Immediate cause of death: Chronic Myocarditis	2 yrs.
Due to: Hypertension	8 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James L. Miller M.D.
M. D. or other

Address: Pikesville, Md. Date signed 9/25/40

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SEP 30 1940
U. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

09360

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH (49-1)

County Baltimore — Registration Dist. No. 44

Village or City Dundalk. — No. 1520 Vesper Ave St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 15 yrs. mos. ds. — How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Bertha Louise Heinlein — If U. S. Veteran, specify WAR

(a) Residence: No. 1520 Vesper ave St., Ward.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	Married

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: William L. Heinlein

6. DATE OF BIRTH (month, day, and year): Feb 2 — 1892

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	7	9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: X

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Baltimore Co. Md.

FATHER

13. NAME: Hugo Koch

14. BIRTHPLACE (city or town) (State or country): Germany

MOTHER

15. MAIDEN NAME: Matilda Henning

16. BIRTHPLACE (city or town) (State or country): Germany

17. INFORMANT (Address): William L. Heinlein 1520 Vesper Ave Dundalk

18. BURIAL, CREMATION, OR REMOVAL — Place: Oaklawn — Date: 9/14, 1940

19. UNDERTAKER (Address): William Bost 1217 St. Paul St.

20. FILED 9/12, 1940 — Helen W. Smullen, Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Sept. (Month) 11, (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 1st, 1940, to Sept 11, 1940

I last saw her alive on Sept 11, 1940; death is said to have occurred on the date stated above, at 1 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Bilateral Carcinoma of Ovaries with metastasis to Stomach	June 1940

Other Contributory Causes of importance:

Name of operation: Exploratory — Date of: June 1940

What test confirmed diagnosis? Biopsy — Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Frank Virgilio M. D.

(Address) Dundalk, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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SEP 14 1940
BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09361

Reg. Diat. No. 4 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Balto

City or town Lansdowne
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 34 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Balto

City or town Lansdowne Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 224 Elizabeth Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Bessie M Helwig

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Paul W Helwig

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 26 1884

8. AGE: Years	Months	Days	If less than one day
56	7	20	hrs. min.

9. Birthplace Hagerstown Md
(Town, county, and state)

10. Usual occupation House work

11. Industry or business

FATHER 12. Name Otho Paugh

13. Birthplace Dont Know

MOTHER 14. Maiden name Anna Hull

15. Birthplace Dont Know

16. Informant Mr Paul W Helwig

Address 224 Elizabeth Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 17 / 40 (month) (day) (year)

Cemetery or crematory London Park

Location 3801 Frederick Ave

18. Funeral director William M Mareck

Address 715 Light St

19. Sept 16 19 40 Geo Kieffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1940, at 6 35 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 Sept 1940 to 14 Sept 1940, and that I last saw h alive on 14 Sept 1940.

	DURATION
Immediate cause of death Cerebral Embolism	2 days
Due to Chronic Endocarditis	4 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H Emanuel Wheeler M. D. or other

Address 2910 Hollins Ferry Rd Date signed 14 Sept 40

Recorded

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OCT 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

09362

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Baltimore

City or town Reisterstown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Gores Mill Road.

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) 4 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Rural near Reisterstown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Gores Mill Road.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Lulu Delosier Hess.

3. (b) Social Security Number none

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Leroy S. Hess.

6(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Dec 4, 1888

8. AGE: Years 57 Months 8 Days 29 If less than one day ___ hrs. ___ min.

9. Birthplace Ellicott City, Md. (Town, county, and state)

10. Usual occupation House wife

11. Industry or business —

FATHER 12. Name John E. Delosier

13. Birthplace Smithsburg. Md.

MOTHER 14. Maiden name Ida Mae Mock

15. Birthplace Smithsburg.

16. Informant Leroy S. Hess.

Address Reisterstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 5, 1940 (month) (day) (year)

Cemetery or crematory Wood Lawn Cem.

Location Gwynn Oak Ave.

18. Funeral director Wm. Berryman & Sons

Address Reisterstown, Md.

19. Sept. 4 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3/ 1940 at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940, to Sept 3 1940, and that I last saw her alive on Sept 2 1940.

Immediate cause of death Carcinoma of Stomach

Due to Cachexia

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

DURATION 1½ yrs

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE James G. Saffell M. D. or other

Address Reisterstown, Md. Date signed 9/3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09363

Reg. Dist. No. 36

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Balto
City or town Pikesville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto
City or town Pikesville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 102 Midhurst Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME John E. Hinrichs

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband ~~or wife~~ Harriette Hinrichs

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 4, 1890

8. AGE: Years	Months	Days	If less than one day
50	5	14	____ hrs. ____ min.

9. Birthplace Baltimore / Md.
(Town, county, and state)

10. Usual occupation Salesman (Retired)

11. Industry or business Wear Ever Aluminum Co

FATHER 12. Name John E. Hinrichs

13. Birthplace Baltimore, Md

MOTHER 14. Maiden name Ella Gail

15. Birthplace Baltimore, Md

16. Informant Mrs. Harriette Hinrichs

Address 102 Midhurst Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 20 1940 (month) (day) (year)

Cemetery or crematory Druid Ridge Cem

Location Pikesville, Md

18. Funeral director William Cook

Address 217 St. Paul St.

19. 9/18 1940 Deputy Mcl Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 1940, at 10-45 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ____ 19__, to ____ 19__, and that I last saw h~~im~~ ~~alive~~ on ____ 19__.

Immediate cause of death	DURATION
Pulmonary Tuber-	
Due to Culosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy No

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. S. Mc Deputy M. Ex M. D. or other

Address Pikesville Md Date signed 9-18-40

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OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (131-b)

Reg. Dist. No. 38

09364

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Baltimore

(b) City or town Lutherville P.O. RFD
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Lutherville RFD
(If outside city or town limits, write RURAL and give town)

(d) Street No.
(If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** John Adam Horn junior

3 (b) If veteran, name war

3 (c) Social Security No. 218-07-2782

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1 1913

8. **AGE:** Years 27 Months Days 14 If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business General Carpentering

FATHER
12. Name John Adam Horn
13. Birthplace Maryland

MOTHER
14. Maiden Name Christina Rausch
15. Birthplace Maryland

16 (a) Informant Mrs Christina Horn
(b) Address Broadway Rd. Lutherville.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 19-40 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore City

18 (a) Funeral director William Cook
(b) Address 1217 St Paul St

19 (a) 9/17/40 (Date rec'd by registrar) (b) W. Carroll Van Horn Deputy No Cor Registrar

MEDICAL CERTIFICATION

20. Date of death September 17 1940 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1940, to Sept 17 1940 and that I last saw him alive on Sept 17 1940.

Immediate cause of death Uremia — Duration 8 days

Due to Chronic Nephritis — 6 mos

Due to Tonsillitis in childhood

Other conditions Myocarditis - Secondary Anemia
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. O. Sellman MD
M. D. or other

Address Towson, Md Date signed Sept 17 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09365

Reg. Dist. No. 39

1. PLACE OF DEATH:

County: Balto Co

City or town: My Ladys manor mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 57 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: My Ladys Manor Mills

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Eli Henry Jesse Houck

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

8.(b) Name of husband or wife: Katherine Boylan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 3 1859

8. AGE: Years	Months	Days	If less than one day
80	11	14	....hrs. ....min.

9. Birthplace: Hanover Pa

(Town, county, and state)

10. Usual occupation: miller

11. Industry or business: Grist mill

FATHER

12. Name: Eli Henry Jesse Houck

13. Birthplace: Not Known

MOTHER

14. Maiden name: Mary Markel

15. Birthplace: Pa

18. Informant: Mrs Beall

Address: White Hall

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 20 40 (month) (day) (year)

Cemetery or crematory: St James

Location: My Ladys Manor Balto Co

18. Funeral director: C E Hunter Son

Address: Jarrettsville Md

19. Sept. 18 1940 (Date rec'd by registrar) Anna Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 17 1940, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 11 1940, to Sept 16 1940

and that I last saw him alive on Sept 16 1940

Immediate cause of death: Heart Disease & Anemia — DURATION:

Due to: Age & Heart Disease

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: H. F. Bradley M. D. or other

Address: Jarrettsville Md Date signed: Sept 18 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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OCT 2 1940
U. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

09366

(S)

1. PLACE OF DEATH

County BALTIMORE Registration Dist. No. 37

Village or City COCKEYSVILLE No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME JAMES EDWARD HOWARD If U. S. Veteran, specify WAR

(a) Residence: No. COCKEYSVILLE, MD St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M.	W	Infant

5e. If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6. DATE OF BIRTH (month, day, and year) 9/29/40

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
STILL BORN			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) COCKEYSVILLE (State or country) MD

FATHER

13. NAME JAMES EDWARD HOWARD

14. BIRTHPLACE (city or town) COCKEYSVILLE (State or country) MD

MOTHER

15. MAIDEN NAME ANNIE CHAPMAN

16. BIRTHPLACE (city or town) COCKEYSVILLE (State or country) MD

17. INFORMANT MRS. ED. HOWARD (Address) COCKEYSVILLE, MD

18. BURIAL, CREMATION, OR REMOVAL Place Groops-Sparks Date Sept. 29, 1940

19. UNDERTAKER London M. Brooks (Address) Sparks, md.

20. FILED , 19 Wilmer Euson Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH September 29, 1940

STILLBIRTH (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

I last saw h elive on , 19 ; deeth is said to heve occurred on the date steted above, et m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importence were as follows:

	Date of onset
STILLBIRTH	
INTRA-UTERINE ASPHYXIA	

Other **Contributary Causes** of Importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death wes due to external causes (VIOLENCE) fill in also tha following:

Accident, suicide, or homicide? Date of Injury , 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in eny way related to occupation of deceased?

If so, specify

(Signed) George Schnitzer M. D.

(Address) Cockeysville, Md

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

RECEIVED OCT 5 1940

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (46-G)

Reg. Dist. No. 30

09367

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Baltimore

(b) City or town Catonsville (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Nunnery Lane

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)

(d) Street No. Nunnery Lane (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** William H. Hunter, Sr.

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna Caroline Hunter

6. (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) June 20, 1871

8. **AGE:** Years 69 | Months 2 | Days 20 | If less than one day _____ hr. _____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Retired Salesman

11. Industry or business Elliott Bookkeeping Co.

FATHER
12. Name Thomas Hunter
13. Birthplace Maryland

MOTHER
14. Maiden Name Ruth Ann Ellers
15. Birthplace Maryland

16 (a) Informant Mr. Wm. H. Hunter, Jr.

(b) Address 856 S. Irvington St., Arlington, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 12, 1940 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director [signature]

(b) Address 1003 W. Baltimore St.

19 (a) 9/12/40 (Date rec'd by registrar) (b) [signature] Registrar

DEPUTY LOCAL

MEDICAL CERTIFICATION

20. Date of death Sept. 10 1940, at 1.15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1940, to Sept 10, 1940, and that I last saw him alive on Sept. 8, 1940.

Immediate cause of death	Duration
Malignant Metastatic Carcinoma of Pancreas	Indefinite
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature James Krenkel M.D. (M. D. or other)

Address 3406 Dolfield Blvd. Date signed

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 16 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B3-a)

09368

CERTIFICATE OF DEATH

Reg. Dist. No. 38

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Baltimore

City or town Ruxton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 Years

Hospital, Institution, or street address where death occurred: None

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County BALTIMORE

City or town RUXTON (If outside city or town limits, write RURAL and give nearest town)

Street No. LABELLE & PAULDING (If rural, give LOCATION)

2.(a) If veteran, name war NONE

3.(a) FULL NAME WILLIAM GEORGE HYNSON

3.(b) Social Security Number 215-07-8651

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife LUCY ERSKINE BAINS HYNSON 6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) MARCH 8. 1872

8. AGE: Years	Months	Days	If less than one day
68	6	2	...hrs. ...min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual occupation RETIRED-V.P. U.S.F.-G. Co.

11. Industry or business INSURANCE

FATHER 12. Name WILLIAM GEORGE HYNSON

13. Birthplace BALTIMORE MD

MOTHER 14. Maiden name ANNA MARIA DUSHANE

15. Birthplace BALTIMORE MD

16. Informant Lucy E. B. Hynson.

Address Ruxton Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 12 1940 (month) (day) (year)

Cemetery or crematory Green Mount

Location Balto Md

18. Funeral director Henry W. Lukens Sons Co

Address McCulloh & Orchard Sts.

19. Sept. 11th 1940 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1940, at 8:15 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 13 to Sept. 10 1940

and that I last saw h.i.m. alive on September 10 1940

Immediate cause of death: Central apoplexy — DURATION 3½ days

Due to: Arterial Hypertension — about 14 months

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Jno. M. Dabney M. D. or other

Address Ruxton, Md. Date signed July 12 1940

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09369

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Balto
City or town: Fort Howard
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 120 S. Washington Ste
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Wm. F. Jacobs

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 18 - 1874

8. AGE: Years: 65 Months: 9 Days: 11 If less than one day ____ hrs. ____ min.

9. Birthplace: Balto Md.
(Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business: Sea Food.

FATHER
12. Name: Wm Jacobs
13. Birthplace: Balto. Md.

MOTHER
14. Maiden name: Josephine Lohman
15. Birthplace: Sweden

16. Informant: Mrs. Mary E. Brugger
Address: 120 S. Washington Str.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Oct. - 2 - 40 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Balto. Md.

18. Funeral director: Geo. H. Sanders
Address: Boardway & North Ave.

19. Sept 30 1940 (Date rec'd by registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 29th 1940, at 6 PM

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__~~

Immediate cause of death: Coronary thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy: No

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: W. T. E. Myse Deputy M Ex
M. D. or other
Address: Pikesville Md Date signed: 9-29-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 10 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

09370

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH: Balto

County

City or town Randallstown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Old Court Road

Stay in hospital or inst. (yrs., or mos., or days) ✓

Stay in this community (yrs., or mos., or days) 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD County BALTO

City or town BALTO Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 4111 BELVIEU AVE

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME William Noah S. Kerr (William Noah S. Kerr)

3. (b) Social Security Number 216-01-9305

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

B (b) Name of husband or wife ANNA RAYCOB KERR

6(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) SEPT 13 1872

8. AGE:

Years	Months	Days	If less than one day
68	0	10	hrs. min.

9. Birthplace BALTO MD (Town, county, and state)

10. Usual occupation MEAT ~~Business~~ Cutter

11. Industry or business Schreiber Bros.

FATHER
12. Name JAMES W. KERR
13. Birthplace BALTO

MOTHER
14. Maiden name MOLLIE GARDNER
15. Birthplace BALTO

16. Informant MRS ANNA R KERR

Address 4111 BELVIEU AVE

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 9 25 1940 (month) (day) (year)

Cemetery or crematory LOUDON

Location Baltimore, Maryland

18. Funeral director Wm. J. Tickner & Sons, Inc.,

Address North & Pa. Avenues

19. 9/24 1940 (Date rec'd by registrar) E. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1940, at 7A M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ~~19~~, to ~~19~~, and that I last saw h ~~alive on~~ ~~19~~

Immediate cause of death Coronary

Due to Thromboosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy No

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. P. O. Mse Lucy M. Tex M.D. or other

Address Pikesville Md. Date signed 9-23-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
SEP 26 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Dr Byerly 09371
3232 Corbett Av

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Catonsville Convalescent Home
Hospital, institution, or street address where death occurred: Mrs Gilston 4 Mos.
How long in hospital or institution? 4 Mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5202 Rushistown Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Hattie Kunert

3.(b) Social Security Number NONE

4. Sex: Female
5. Color or race: White
6.(a) Single-married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Fred Kunert
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 91 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Henderson N. C (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace Unknown
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown
16. Informant Mrs R. O. Rogers
Address Lily Dale N Y
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/2/40 (month) (day) (year)
Cemetery or crematory Western
Location Baltimore Md
18. Funeral director William Cook
Address 1217 St Paul St Baltimore Md
19. 9-30 (Date rec'd by registrar) 19 40 H C Andreae Registrar
DEPUTY LOCAL

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29th 1940, at 7 30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1939 to Sept 29th 1940
and that I last saw her alive on Sept 29th 1940
Immediate cause of death Uraemia

	DURATION
Due to Arterio sclerotic Cardio-vascular Renal disease	
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations none
Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M P Byerly M D
M. D. or other
Address 3045 W North A Date signed 9/29/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 1 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (134-C)

09372

CERTIFICATE OF DEATH

Reg. Dist. No. 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Texas
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Balto. Co., Home.
Stay in hospital or inst. (yrs., or mos., or days) 10 mo. 17 da.
Stay in this community (yrs., or mos., or days) 10 mo. 17 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Joseph Lang

3. (b) Social Security Number —

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1881

8. AGE:

Years	Months	Days	If less than one day
59	7	26	hrs. min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Baker + Farm Laborer

11. Industry or business

FATHER
12. Name Edward Lang
13. Birthplace Germany

MOTHER
14. Maiden name Ann Boff
15. Birthplace Germany

16. Informant Balto. Co., Home Register
Address Texas, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 20. 1940 (month) (day) (year)

Cemetery or crematory Balto. Co., Home
Location Texas, Md.

18. Funeral director Landon Brooks
Address Sparks, Md.

19. Sept. 20 1940 (Date rec'd by registrar) Wm. J. Chilcoat Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1940, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 2 1939 to Sept 19 1940, and that I last saw him alive on Sept 19/40 1940.

	DURATION
Immediate cause of death: Chronic Valvular Endocarditis	1 yr.
Due to: Chronic Nephritis	1 yr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wilmer L. Emrich M.D.
M. D. or other
Address Cockeysville Date signed Sept 19/40

RECEIVED
OCT 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

09373

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore Co.
City or town: Stemmer's Run
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Norris Lane Stemmer's Run
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 18 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Norris Lane
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Gus Lawson Jr.

3. (b) Social Security Number: 215-05-9086

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife: Helen Lawson
6(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): July 18 - 1889

8. AGE:

Years	Months	Days	If less than one day
51	1	17	hrs. min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business: for Eyring
FATHER
12. Name: Gustavis Lawson
13. Birthplace: Baltimore Md.
MOTHER
14. Maiden name: Emma Leverman
15. Birthplace: Baltimore Md.
16. Informant: Arthur Lawson (Son)
Address: Norris Lane Stemmer's Run Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 9 - 1940 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Eastern Ave Road
18. Funeral director: Lilly & Zeiler Inc.
Address: 403 S. Wolfe St.
19. Sept. 6 19 40 J. S. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 5 1940 at 11:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1 1940 to Sept. 5 1940 and that I last saw him alive on Sept. 4 1940

Immediate cause of death	DURATION
Acute Gastro-intestinal Hemorrhage	1 day
Due to Carcinoma of stomach	6 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations: Carcinoma of stomach
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Israel J. Zeiler M. D. or other
Address: 700 E. Pratt St. Date signed: 9/5/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

09374

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months, 5 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 7 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2018 Kennedy Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: James Levanis

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 15, 1903

8. AGE: Years	Months	Days	If less than one day
37	4	4	hrs. min.

9. Birthplace: Greece
(Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business: Restaurant

FATHER
12. Name: Leo Levanis
13. Birthplace: Greece

MOTHER
14. Maiden name: Rose Grievas
15. Birthplace: Greece

16. Informant: Hospital Records
Address:

17. Burial, cremation, or removal. Which?: Burial Date thereof: 9/24/40 (month) (day) (year)
Cemetery or crematory: Wood Lawn
Location: Balto Md

18. Funeral director: J. Frances Reese
Address: West minster Md

19. 9/19 1940 (Date rec'd by registrar) DEPUTY LOCAL Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19, 1940, at 8:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 14, 1940, to September 19 1940 and that I last saw him alive on September 19, 1940

Immediate cause of death	before	DURATION 1940
Due to: Generalized syphilis	"	"
Due to:		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Serge Androp
Serge Androp, M.D. M. D. or other
Address: Spring Grove St. Hosp. Date signed: 9-19-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 1 1940
BUREAU V. S.

09375

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH

County Balto. Co.

City or town Glenarm
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harold F. Lonergan

3. (b) Social Security Number

4. Sex M. | 5. Color or race W. | 6. (a) Single, married, widowed, or divorced M.

8 (b) Name of husband or wife Ethel Lonergan*

6(c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) May 16 - 1896

8. AGE: Years 44 | Months 4 | Days 11 | If less than one day ___ hrs. ___ min.

9. Birthplace Boston
(Town, county, and state)

10. Usual occupation Construction Engineer

11. Industry or business

FATHER
12. Name David Lonergan
13. Birthplace Boston

MOTHER
14. Maiden name ~~Unknown~~ Lily Kelter*
15. Birthplace ~~Unknown~~ Boston, Mass.

16. Informant Lauretta Lonergan

Address 3503 Clarendon Rd.

17. Cremation Brookline Date thereof Oct. 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loudon Park

Location Frederick Rd. Balto.

18. Funeral director Clarence E. Arthur

Address Fork Md.

19 9-30-40 19 W. McKimmon
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1940, at 4 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 28 1940, to ___ 19___, and that I last saw him alive on Sept. 28, 1940.

Immediate cause of death Coronary Thrombosis — DURATION 1 1/2 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clifford F. Hudson M. D. or other

Address Fork, Md. Date signed 9/29/40

*Auth: Letter from doctor Perm. File "Lonergan" 12/13/44 [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(131-a)

09376

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Baltimore

City or town: Glyndon
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Glyndon
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 301 Central Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: Home address - 48 S. Merrick Ave, Merrick, Long Island - New York

3.(a) FULL NAME: Annie M. Lord

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Louis L. Lord

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 9, 1858

8. AGE: Years	Months	Days	If less than one day
82	8	4	..... hrs. ..... min.

9. Birthplace: New York
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Geo. P. Mott
13. Birthplace: Long Island, N. Y.

MOTHER
14. Maiden name: Elizabeth Carman
15. Birthplace: Merrick, Long Island

16. Informant: Mrs. Albert M. Smith
Address: 301 Central Avenue, Glyndon

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/15/40 (month) (day) (year)

Cemetery or crematory: Greenfield

Location: Hempstead, Long Island

18. Funeral director: Wm. J. Tickner & Sons, Inc.,
Address: North & Pa. Avenues

19. Sept. 14 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13, 1940, at 12:55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1937 to Sept 13 1940 and that I last saw her alive on Sept 13 1940

Immediate cause of death: Uremic Coma — DURATION: 2 days

Due to: Chronic nephritis

Due to: arteriosclerosis (Senile)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Reisterstown, Md. Date signed: 9/13/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-C)

09377

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 611 d Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Thelma MAJOR

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	A A	Single

6.(b) Name of husband or wife: Child
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 7, 1927

8. AGE: Years: 13 yrs 12 | Months: 11 | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Semora, North Carolina (Town, county, and state)

10. Usual occupation: Child

11. Industry or business: —

FATHER
12. Name: Soloman Major
13. Birthplace: Hal. fax Co. Va.

MOTHER
14. Maiden name: Florence Faulkner
15. Birthplace: Person Co. North Carolina

16. Informant: (Mother) Florence Major
Address: 611 d Street Sparrows Point

17. Burial (Burial, cremation, or removal, Which?) Date thereof 9-13-40 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: A. A. Co.

18. Funeral director: Lond W. Chase & Son
Address: 638 N. Gilmor St.

19. Sept 12 1940 (Date rec'd by registrar) Dorcas L. Harbaugh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 12 1940 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1940, to Sept 12 1940
and that I last saw her alive on Sept 12 1940

	DURATION
Immediate cause of death: Carcinoma of roof of mouth	1/1/40
Due to: Metastases to maxillary sinus and left nose	4/40
Due to: Anemia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. W. Shiff M. D. or other
Address: 1422 E. Chase St Date signed: 9/12/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 3 1940
BUREAU V. S.

09378

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years, 11 months, 21 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 11 years, 11 months, 21 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1028 North Central Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Ella Mann

3.(b) Social Security Number: none

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years: 75 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

FATHER
12. Name: unk
13. Birthplace

MOTHER
14. Maiden name: unk
15. Birthplace

16. Informant: Hospital records
Address: Spring Grove St. Hosp.
Catonsville, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Sept 14, 1940 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hosp

Location: Catonsville Md

18. Funeral director: Spring Grove State Hosp

Address: Catonsville Md

19. 9/9 (Date rec'd by registrar) 1940 [signature] Registrar

DEPUTY LOCAL

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9, 1940, at 1:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19, 1936, to September 9, 1940 and that I last saw her alive on September 9, 1940

Immediate cause of death	DURATION
Carcinoma of right lung, liver and diaphragm	4 years
Due to Carcinoma of left breast over	" "
Due to	
Other conditions Senile psychosis over	12 years

(Include pregnancy within 3 months of death)

Major findings of operations: On October 8, 1936 were: carcinoma of left breast. Date of op. 10-8-36

Autopsy results: As given above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Serge Androp
Serge Androp, M.D. M. D. or other

Address: Spring Grove St. Hosp. Date signed: 9-9-40

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 1 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

CERTIFICATE OF DEATH

09379

Reg. Dist. No. 30.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months, 15 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 8 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of motber)

State: Maryland County: Queen Anne's

City or town: Churchill (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Jane McDaniel

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 26, 1886

8. AGE: Years	Months	Days	If less than one day
54	1	21	..... hrs. ..... min.

8. Birthplace: Queen Anne's County, Maryland. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Homes

FATHER — 12. Name: ? McDaniel

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: ? Hawkins

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 18, 1940 (month) (day) (year)

Cemetery or crematory: Church Hill

Location: Church Hill Md

18. Funeral director: W. H. Hood

Address: Church Hill Md

19. 9/17 1940 (Date rec'd by registrar) Registrar

DEPUTY LOCAL

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 17, 1940, at 4:38 a m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1940, to Sept. 17, 1940 and that I last saw her alive on September 17, 1940

Immediate cause of death	DURATION
Carcinoma of the right antrum	December, 1938
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? No (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): None

Means of injury: None Injured at work?

23. SIGNATURE: Robert E. Gardner, M.D. Robert E. Gardner M. D. or other

Address: Spring Grove Hospital Date signed: 9/17/40

RECEIVED
OCT 1 1940
BUREAU V. S.

232

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

Reg. Dist. No. 09388 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months, 5 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 8 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 5401 Elsrode Avenue (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mollie McKew

3.(b) Social Security Number: none

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: James F. McKew

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 7, 1864

8. AGE: Years 76 | Months 7 | Days 13 | If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: James Porter
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Elizabeth McNeill
15. Birthplace: Ireland

16. Informant: Hospital Records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9-23-40 (month) (day) (year)

Cemetery or crematory: Balto ~~9 23 40~~

Location: Balto Md.

18. Funeral director: Wm Cook Inc

Address: 1217 St Paul St

19. 9/21 1940 (Date rec'd by registrar) [signature] Registrar

DEPUTY LOCAL

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 20, 1940, at 8:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15, 1940, to September 20 1940 and that I last saw her alive on September 20, 1940

Immediate cause of death	DURATION
Acute bilateral pyelonephritis before	1940
~~Due to~~ Hypostatic pneumonia, bilateral	10 days
Due to	
Other conditions Senile psychosis before	1940

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: As given above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Serge Androp M. D. or other

Serge Androp, M.D.

Address: Spring Grove St. Hosp. Date signed 9-21-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 1 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (96)

09381

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH: Balto.

County

City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto

City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American.

3. (a) FULL NAME Allan McLane

3. (b) Social Security Number

4. Sex: Male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Augusta James

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 8. 1864.

8. AGE: Years 75 | Months 9 | Days 7 | If less than one day ..... hrs. ..... min.

9. Birthplace: Balto
(Town, county, and state)

10. Usual occupation: Lawyer

11. Industry or business

FATHER
12. Name: James Latimer McLane
13. Birthplace: Md.

MOTHER
14. Maiden name: Fanny King
15. Birthplace: New York.

16. Informant: Mrs R. Curzon Hoffman

Address: Garrison. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: SEPT. 18 '40 (month) (day) (year)

Cemetery or crematory: St Thomas Garrison Md

Location: Garrison Md

18. Funeral director: A. W. Jenkins & Sons Co

Address: Orchard & Mc Culloh Ave

19. 9-16- 1940 (Date rec'd by registrar) E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 15 1940, at 5 20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1936, to Sept 15 1940 and that I last saw him alive on Sept 15 1940

Immediate cause of death	DURATION
~~Contrast fraction~~ Ruptured abdominal aneurysm	[illegible]
Due to arteriosclerosis & Hypertension	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: Ruptured abdo aneurysm

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Palmer T C Williams M. D. or other

Address: Pikesville. Md Date signed: Sept 15.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93-2)

Reg. Dist. No. 44

09382

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Balto County

(b) City or town _____ (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Old Phil. Rd. & White ave

(d) Length of stay in hospital or inst. (yrs., mos., or days) _____

(e) Length of stay in this community (yrs., mos., or days) Life

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Balto

(c) City or town _____ (If outside city or town limits, write RURAL and give town)

(d) Street No. Old Phil. Rd & White ave (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Daniel John McNamara

3 (b) If veteran, name war _____

3 (c) Social Security No. _____

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ or wife Anna Josephine

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov 29 1891

8. AGE: Years 48 Months 10 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace Balto (Town, county, and state)

10. Usual occupation Custom Inspector

11. Industry or business

FATHER

12. Name Daniel McNamara

13. Birthplace Ireland

MOTHER

14. Maiden Name Elizabeth Green

15. Birthplace Balto

16 (a) Informant Anna Josephine McNamara

(b) Address Old Phil. Rd & White ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 (month) 2 (day) 40 (year)

(c) Cemetery or crematory New Cathedral

Location Old Frederick Rd

18 (a) Funeral director Martin W. E. Dippel

(b) Address 37 S. Ann St

19 (a) Oct 1-40 (Date rec'd by registrar) (b) J. S. Carroll Registrar

MEDICAL CERTIFICATION

20. Date of death Sept 30 1940, at 6:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1940, to Sept 30 1940, and that I last saw him alive on Sept 30 1940.

Immediate cause of death Cerebral apoplexy — Duration 1 day

Due to Arteriosclerotic Cardio vascular disease with

Due to Hypertension

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ (Specify type of place) While at work? _____

(e) Means of injury _____

23. Signature T. M. Baumgardner M. D. or other

Address Raspeburg Md Date signed 9/30/40

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 10 1940
BUREAU V. S.

09383

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 2 mos., 23 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 2 mos., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 702 Frederick Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mrs. Alice Middlecamp

3.(b) Social Security Number

212-09-1368

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Carl Middlecamp

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 4, 1893

8. AGE: Years	Months	Days	If less than one day
47	8	12	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Saleswoman

11. Industry or business: Unknown

FATHER
12. Name: Harry Elder
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Carrie Williams
15. Birthplace: Harford County, Maryland

16. Informant: Mrs. Alice Middlecamp

Address: 702 Frederick Ave., Catonsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 18, 1940 (month) (day) (year)

Cemetery or crematory: Mount Olivet Cemetery

Location: Baltimore, Maryland

18. Funeral director: George A. Farley

Address: Frederick Ave., Catonsville, Md.

19. 9/16/40 19 (Date rec'd by registrar) J. Frank Meduey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 16, 1940, at 12:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24, 1940, to Sept. 16, 1940 and that I last saw her alive on Sept. 16 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9 mos.
Due to Tubercle Bacilli	
Due to	
Other conditions Mitral Regurgitation	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: No operations

Date of op.

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. (M.D. or other)

Address: Mt. Wilson, Md. Date signed: 9/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (94E)

09384

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:
County Baltimore
City or town Fullerton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Belair Road and Putty Hill Avenue
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Belair Rd.&Putty Hill Ave. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Fullerton
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Henry J. Mullhausen

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Annie A. Mullhausen
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): January 22, 1884

8. AGE: Years 56 | Months 9 | Days 7 | If less than one day ____ hrs. ____ min.

9. Birthplace: Balto. Co., Md. (Town, county, and state)
10. Usual occupation: Saloon Keeper
11. Industry or business
FATHER
12. Name: John Mullhausen
13. Birthplace: Balto. Co., Md.
MOTHER
14. Maiden name: Elizabeth Stedtler
15. Birthplace: Balto. Co., Md.
16. Informant: Mrs. Henry J. Mullhausen
Address: Fullerton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 1, 1940 (month) (day) (year)
Cemetery or crematory: Parkwood Cemetery
Location: Balto., Md.
18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Road
19. 9/30 1940 (Date rec'd by registrar) Mrs. G. A. Fritz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29th 1940, at 1:30 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 24 1940, to Sept 29th 1940, and that I last saw him alive on Sept 29th 1940.

Immediate cause of death: Angina Pectoris — DURATION: 5 days
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: Eddie H. Benson M. D. or other
Address: 1 W. Overlea Ave. Date signed 9/30/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 2 1940
BUREAU V. S.

09385

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH: Balto

County Essex

City or town

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County

City or town Balto. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 4314 La Salle Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME John George Nollmeyer

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Suzanne

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb 16 1850

8. AGE: Years 90 | Months 7 | Days 5 | If less than one day ____ hrs. ____ min.

9. Birthplace: Balto (Town, county, and state)

10. Usual occupation: Ret.

11. Industry or business

FATHER
12. Name: ?
13. Birthplace: Holland

MOTHER
14. Maiden name: Mary ?
15. Birthplace: Holland

16. Informant: Mamie Nollmeyer

Address: 4314 La Salle Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 24 40 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: 4400 Belair Rd.

18. Funeral director: Martin W. C. Dippel

Address: Lombard & Ann St.

19. Sept. 22 1940 (Date rec'd by registrar) J. G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1940, at ?4 M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ____ 19__, to ____ 19__, ~~and that I last saw h~~ ____ alive on ____ 19__.

Immediate cause of death: Valvular heart disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy no

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Cate of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ injured at work?

23. SIGNATURE W. P. T. Myer Lupy M Tex M. D. or other

Address Pikesville Md Date signed 9.21.40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 3 1940
BUREAU V. S.

STATE OF MARYLAND
~~BALTIMORE CITY~~ ~~HEALTH~~ DEPARTMENT

CERTIFICATE OF DEATH (131-a)

Registered No. 38
09386

1. PLACE OF DEATH: Co
(a) Baltimore ~~City,~~ Maryland
(b) Street address 120 E. Chesapeake ave
(c) Hospital or institution: None
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in ~~Baltimore~~ TOWSON (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 E Chesapeake ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** MILES NELSON

3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Sex M
5. Color or race Col
6 (a) Single, married, widowed, or divorced. M

6 (b) Name of ~~husband~~ or wife Martha Nelson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1869

8. **AGE:** Years 71 | Months 1 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James Nelson
13. Birthplace Virginia

MOTHER
14. Maiden Name Lucy Day
15. Birthplace Virginia

16 (a) Informant Martha Nelson
(b) Address 102 Chesapeake Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11, 1940 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson, Md.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 David Hill Ave

19 (a) 9/10/40 (Date rec'd by registrar) (b) [illegible] Deputy Local Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 9-8-40 19 , at 3 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 4 1940, to Sept 8, 1940, and that I last saw him alive on Sept 8 1940

Immediate cause of death Cardio-Renal disease — Duration ?

Due to

Due to

Other Conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice Adams M. D.
Address 312 E 23rd St. Date signed 9-10-40

VS 3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 12 1940
BUREAU V. S.

09387

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County Balt. Co.
City or town Glenarm Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balt.
City or town Glenarm Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3.(a) FULL NAME Thomas S. Nichols

3.(b) Social Security Number

4. Sex M. | 5. Color or race W. | 6.(a) Single, married, widowed, or divorced Married

6 (b) Name of ~~husband or~~ wife Medora Burton

6(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) April 22-1867

8. AGE: Years ✓ 73 | Months 5 | Days 6 | If less than one day ___ hrs. ___ min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Nursery man

11. Industry or business

FATHER
12. Name Thos Nichols
13. Birthplace Md.

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Medora Burton
Address Glenarm Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 30-1940 (month) (day) (year)
Cemetery or crematory Salem M. E. Cem
Location Upper Falls Md.

18. Funeral director Clarence E. Arthur
Address Fork Md.

19. 9-29-40 (Date rec'd by registrar) 19 W M Hammett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28, 1940, at 11 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 22, 1939, to Sept. 28 1940, and that I last saw him alive on Sept. 27, 1940.

Immediate cause of death	DURATION
Apoplexy	18 mos
Due to Hypertensive Cardiovascular Disease	4 yrs
Due to Arteriosclerosis	10 yr
Other conditions Hypertrophy of Prostate (Include pregnancy within 3 months of death)	2 yrs

Major findings:
Of operations Transurethral Resection.
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clifford F. Hudson M. D. or other
Address Fork Md. Date signed 9/29/40

VS A15 (I) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-1)

09388

CERTIFICATE OF DEATH

Reg. Diat. No. 31

1. PLACE OF DEATH:
County Baltimore
City or town Rockdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Rockdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. Liberty Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Thomas Patrick O'Donnell Sr.

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Ada D O'Donnell
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 8. 1858

8. AGE: Years	Months	Days	If less than one day
82	6	16	..... hrs. ..... min.

9. Birthplace Clarksville Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name James O'Donnell
13. Birthplace Ireland.

MOTHER
14. Maiden name Mary Maddy
15. Birthplace Ireland.

16. Informant Mrs Ada D O'Donnell
Address Liberty Rd. Rockdale, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-27-40 (month) (day) (year)
Cemetery or crematory St Louis
Location Clarksville Md.
16. Funeral director F. C. Higinbotham Jr.
Address Ellicott City Md
19. Sept 26 1940 (Date rec'd by registrar) Wm E Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1940, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940, to Sept 24, 1940, and that I last saw him alive on Sept 24 1940.

	DURATION
Immediate cause of death	
Broncho-pneumonia	3 days
Due to	
Cardio-vascular Disease	5
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or other
Address Randallstown Date signed 9/24/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93-2) Reg. Dist. No. 38

CERTIFICATE OF DEATH

09389

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Carney (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Magledt Avenue
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 2 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Carney (If outside city or town limits, write RURAL and give town)
(d) Street No. Magledt Avenue (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Emma Virginia Ogle

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Samuel V. Ogle

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) August 29, 1857

8. AGE: Years 83 | Months - | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: David Grove
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Rachel High
15. Birthplace: Maryland

16 (a) Informant: Mrs. Emma Bishop
(b) Address: Magledt Ave., Carney

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27, 1940 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: [signature]
(b) Address: 1003 W. Baltimore St.

19 (a) 9/25/40 (Date rec'd by registrar) (b) G. M. Bacon Registrar

MEDICAL CERTIFICATION

20. Date of death: September 24 19 40 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22 19 40, to Sept. 24 19 40, and that I last saw he alive on Sept. 24 19 40.

Immediate cause of death	Duration
Chr. myocarditis	1 yr
Due to arteriosclerotic cardiovascular disease	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. **Signature** S. A. Alessi M.D. (M. D. or other)

Address 6217 Harford Road Date signed 9-25-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (77) Reg. Dist. No. 32

69390

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Villa Nova. (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Campfield Road.
(d) Length of stay in hospital or inst. (yrs., mos., or days) ~
(e) Length of stay in this community (yrs., mos., or days) ~

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Villa Nova. (If outside city or town limits, write RURAL and give town)
(d) Street No. Campfield Road (If rural give location)
(e) If foreign born, how long in U. S. A.? 85 years years

3 (a) **FULL NAME** Mary Ann Pape

3 (b) If veteran, name war ~ | 3 (c) Social Security No. ~

4. Sex Female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ~

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 30 - 1836

8. AGE: Years 94 | Months 7 | Days 7 | If less than one day ____hr. ____min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John Christian Pape
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Pape
15. Birthplace Germany

16 (a) Informant Mrs. Raymond Childs
(b) Address Campfield Rd. Pikesville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7 1940 (month) (day) (year)
(c) Cemetery or crematory Presbyterian Groves
Location York Rd. Towson Md

18 (a) Funeral director Frank H. Neuret
(b) Address Pikesville, Md.

19 (a) 9/7/40 (Date rec'd by registrar) (b) E. E. Nichols Registrar

MEDICAL CERTIFICATION

20. Date of death September 6 1940, at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1940, to Sept 5 1940, and that I last saw him alive on Sept 5 1940.

Immediate cause of death	Duration
Arteriosclerosis	
Due to	
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. E. Nichols M.D.
M. D. or other
Address Pikesville Md Date signed Sept

RECEIVED
OCT 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

09391

(93-d)

1. PLACE OF DEATH

County Balto — Registration Dist. No. 30.

Village or City Catonsville No. Spits Home St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. 13 ds. How long in U.S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME William J. Peregoy If U. S. Veteran, specify WAR

(a) Residence: No. 1412 Wilkens Ave Balto St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa H. Peregoy

6. DATE OF BIRTH (month, day, and year) DEC 19, 1854

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	9	7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation ?

12. BIRTHPLACE (city or town) (State or country) Balto Md

FATHER

13. NAME James Peregoy

14. BIRTHPLACE (city or town) (State or country) ?

MOTHER

15. MAIDEN NAME Cox

16. BIRTHPLACE (city or town) (State or country) ?

17. INFORMANT Mrs W A Melvin

(Address) 1412 Wilkens Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Burial Date Sept. 30, 1940

19. UNDERTAKER J. Fenw. McCully

(Address) 130 E Fort Ave

20. FILED 9/26, 1940 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Sept 26, 1940

(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Sept 14, 1940, to Sept 26, 1940

I last saw h— alive on Sept 26, 1940; death is said to have occurred on the date stated above, at 10 A m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance are as follows:

	Date of onset
Cerebral Arterio Sclerosis	6 mon

Other Contributory Causes of importance:

Chr Myocar Dfts —

Name of operation ... Date of ...

What last confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) James Monroe M. D.

(Address) Catonsville Md

Answer blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93d) Reg. Dist. No. 42

09392

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Baltimore

(b) City or town Arbutus (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 4140 Wilkens Ave.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Arbutus (If outside city or town limits, write RURAL and give town)

(d) Street No. 4140 Wilkens Ave. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Adam Pfaff

3 (b) If veteran, name war

3 (c) Social Security No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth Pfaff

6. (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) August 13, 1868

8. AGE: Years 72 Months 1 Days 7 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual occupation Cabinet Maker

11. Industry or business

FATHER
12. Name John Pfaff
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Bowers
15. Birthplace Germany

16 (a) Informant Miss Pearl E. Pfaff

(b) Address 4140 Wilkens Ave., Arbutus

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 23, 1940 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location Baltimore, Md.

18 (a) Funeral director [signature]

(b) Address 1003 W. Baltimore St.

19 (a) Sept 22 40 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. Date of death September 20 1940, at 11.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1930, to Sep 20 1940, and that I last saw him alive on Sep 20 1940.

Immediate cause of death Chronic Myocarditis — Duration 10 Years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edward A. Morgan M. D. or other

Address 4201 Hooper Ave. Ridgewood, Md. Date signed Sep 21-40

VS. A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 27 1940
BUREAU V. S.

09393

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (136)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Baltimore

City or town: Eudowood Sanatorium, Towson, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days): 2 years 6 mo.

Stay in this community (yrs., or mos., or days): Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R.R. # 6.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No.

3. (a) FULL NAME: Mary Regina Popp

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married.

B (b) Name of husband or wife: John Francis Popp.

6(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): November 18, 1883

8. AGE: Years: 56 Months: 10 Days: 3 If less than one day: hrs. min.

9. Birthplace: Baltimore, Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: John G Miller
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary B Neubauer
15. Birthplace: Germany.

16. Informant: Personal History - Hospital Record

Address: Eudowood Sanatorium, Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/24/40 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Balto Md

18. Funeral director: George J. Ruth Inc

Address: 1735 Harford Ave

19. 9/27 (Date rec'd by registrar) 19 40 W. Carroll Van Storm Deputy Notary Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 21 1940, at 7:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 1938 to September 21 1940, and that I last saw her alive on September 21 1940.

Immediate cause of death: Pulmonary Tuberculosis

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: None.

DURATION: April 1935

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. A. Bridges M. D. or other

Address: Towson, Md. Date signed: 9-21-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 25 1940
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vitel Stetistics, Baltimore (93d) Reg. Dist. No. 38

CERTIFICATE OF DEATH

09394

1. PLACE OF DEATH:
(a) County BALTIMORE
(b) City or town TOWSON (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 2 BURKE AVENUE
(d) Length of stay in hospital or inst. (yrs., mos., or days) ——
(e) Length of stay in this community (yrs., mos., or days) 44 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town TOWSON (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 BURKE AVENUE (If rural give location)
(e) If foreign born, how long in U. S. A.? ——— years

3 (a) FULL NAME ELIJAH McCLENNAN PRICE

3 (b) If veteran, name war: NONE

3 (c) Social Security No. 212-16-3131-A

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife FLORENCE CHILCOAT PRICE

6. (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) SEPT. 23, 1867

8. AGE: Years 72 | Months 11 | Days 13 | If less than one day ——hr. ——min.

9. Birthplace FORESTON, BALTO. CO., MD. (Town, county, and state)

10. Usual occupation SAFE DEPOSIT ASSISTANT

11. Industry or business MERCANTILE TRUST CO.

FATHER
12. Name MORDECAI PRICE
13. Birthplace BALTO. CO., MARYLAND

MOTHER
14. Maiden Name RACHEL ARMACOST
15. Birthplace BALTO. CO., MARYLAND.

16 (a) Informant MRS. FLORENCE C. PRICE
(b) Address 2 BURKE AVE., TOWSON, MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 9, 1940 (month) (day) (year)
(c) Cemetery or crematory FOREST BAPTIST CEM.
Location FORESTON, BALTO. CO., MD.

18 (a) Funeral director John Bunce Sons
(b) Address Towson, Maryland

19 (a) SEP 9 1940 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. Date of death SEPT. 6, 1940 at 10:00 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1940 to Sept. 7 1940, and that I last saw him alive on Sept. 6th 1940

Immediate cause of death	Duration
Chronic Myocarditis,	
Due to Hypertension and Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings: ✓
Of operations
Of autopsy ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert W. Allison M.D. M. D. or other

Address 6 Bushleigh Rd. Date signed 9-7-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

09395

CERTIFICATE OF DEATH

Reg. Dist. No. 39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Phoenix
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 83 yrs 10 Mos. 7 Das.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Phoenix Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME George Washington Price

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White.	Widowed

6 (b) Name of husband or wife (Dunbaugh) Price
6(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1856

8. AGE: Years	Months	Days	If less than one day
83	10	7	——hrs. ——min.

9. Birthplace Phoenix, Balto Co, Md.
(Town, county, and state)
10. Usual occupation Rural Mail Carrier
11. Industry or business U.S. Mail
FATHER 12. Name Daniel Price
13. Birthplace Balto. Co., Md.
MOTHER 14. Maiden name Rachel Gaines
15. Birthplace Balto. Co. Md.
16. Informant Mrs. Geo. Royston
Address Phoenix, Md.
17. Jessops (Burial, cremation, or removal. Which?) Date thereof Sept. 18 1940 (month) (day) (year)
Cemetery or crematory Jessops
Location Sparks, Balto Co., Md.
18. Funeral director Landon M. Brooks
Address Sparks, Md.
19. Sept. 17 1940 (Date rec'd by registrar) Anna Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1940, at 11 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 15 1940, to Sept 16 1940, and that I last saw him alive on Sept 15 1940.

	DURATION
Immediate cause of death Coronary Thrombosis	1 day
Due to Arteria sclerosis	5 yrs
Due to Senility.	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wilmer C. Ensor M.D.
M. D. or other
Address Cockeysville Md Date signed Sept 16/40

RECEIVED
OCT 3 1940
BUREAU Y. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

94a

09396

1. PLACE OF DEATH

County Baltimore Registration Dist. No. 41

Village or City ____ No. ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of rasidance in city or town whare deeth occurred 52 yrs. ____ mos. ____ ds. How long in U. S. if of foreign birth? 52 yrs. ____ mos. ____ ds.

2. FULL NAME Mateusz Przybyszewski If U. S. Veteran, specify WAR ____

(a) Residence: No. Box 219 Gorman Hill Road Ward ____
(Usual place of abode)
If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	Married

5a. If marriad, widowed, or divorced HUSBAND of (or) WIFE of Honorata Przybyszewski

6. DATE OF BIRTH (month, day, and year) Sep 9 1876

7. AGE	Yaars	Months	Deys	If LESS than 1 day, ____ hrs. or ____ min.
64	64	—	15	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Holy Rosary Cemetery Keeper

9. Industry or business in which work wes done, as SILK MILL, SAW MILL, BANK, etc. Holy Rosary Church

10. Date deceasad last workad at this occupation (month and year) 9/23/40

11. Totai time (yaars) spent in this occupetion 23

12. BIRTHPLACE (city or town) Poland
(State or country)

FATHER

13. NAME Michael Przybyszewski

14. BIRTHPLACE (city or town) Poland
(State or country)

MOTHER

15. MAIDEN NAME Helen

16. BIRTHPLACE (city or town) Poland
(State or country)

17. INFORMANT Mrs. Honorata Przybyszewski
(Address) Box 219 Gorman Hill Road

18. BURIAL, CREMATION, OR REMOVAL
Place Holy Rosary Date 9/26/40

19. UNDERTAKER John J. Weber
(Address) 401 S. Chester Street

20. FILED 9/24, 1940 Eileen M. Jamison Deputy
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH
Sept 24 1940
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 1940, to Sept 23, 1940

I last saw him alive on Sept 23, 1940; death is said to heve occurred on the data stated ebove, at 2:30 P.m.

The PRINCIPAL CAUSE OF DEATH end related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	July 1940
Coronary Thrombosis	Sept 23 1940

Othar Contribntory Causes of Importanca:

Nama of oparation ____ Date of ____

Whet tast confirmad diagnosis? ____ Was there an autopsy? No

23. If death was due to externel causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Dete of Injury ____, 19____

Where did injury occur? ____
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any wey related to occupation of deceesed? No

If so, specify ____

(Signed) Melvin L. Solomon M.D.

(Address) 129 S. Broadway Balto Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE [illegible] WITH UNFADING INK—THIS IS A PERMANENT RECO[illegible]very item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

RECEIVED
SEP 26 1940
BUREAU U.S.

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

09397

Reg. Dist. No. 31

1. PLACE OF DEATH:

County: 6301 Baltimore Heights Ave

City or town: Woodlawn

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 6301 Liberty Heights Ave

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 1 Year

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto.

City or town: Woodlawn Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 6301 Liberty Hgts Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Emma Busick Pryor

3. (b) Social Security Number:

4. Sex: F.

5. Color or race: W

6. ~~(a) Single~~, married, widowed, or ~~divorced~~: Widow

6 (b) Name of husband or wife: George H. Pryor

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct 8th 1864

8. AGE: Years: 75 Months: 10 Days: 24 If less than one day ____ hrs. ____ min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER 12. Name: James H. Busick

13. Birthplace: Balto Md

MOTHER 14. Maiden name: Elizabeth A Sullivan

15. Birthplace: Balto Md

16. Informant: Mrs Genevieve Barker

Address: 6301 Liberty Heights Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 4 - 1940 (month) (day) (year)

Cemetery or ~~crematory~~: Woodlawn

Location: Woodlawn Md

18. Funeral director: Vertram Love

Address: 2224 N Charles St

19. Sep 2 1940 (Date rec'd by registrar) Henry A. Emmons Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 2 1940, at 3:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 16 1940, to Sept. 2 1940 and that I last saw her alive on Sept. 2 1940.

Immediate cause of death: Arteriosclerotic cardio Vascular Disease (Senile) — DURATION: Several Years

Due to: Chronic Myocarditis

Due to: Acute Heart Failure (Auxiliary) 1 day

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Luther E. Little M.D. M. D. or other

Address: 928 N. Charles St Balto. City Date signed: 9/2/40

VS A15 (I) (T) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
[illegible]
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (13-B)

Reg. Dist. No. 12-41

09398

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Baltimore

(b) City or town Fort Howard (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Box 226A, Route 10

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 5 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Fort Howard, Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. Box 226A, Route 10 (If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Martha Catherine Pyles

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Caleb Pyles

6. (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1886

8. AGE: Years 54 Months 7 Days 0 If less than one day _____ hr. _____ min.

9. Birthplace Hundred, W. Va. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

FATHER 12. Name Jesse Soles

13. Birthplace Hundred, W. Va.

MOTHER 14. Maiden Name ... Church

15. Birthplace Hundred, W. Va.

16 (a) Informant Tracy Pyles

(b) Address Spanish Point, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/40 (month) (day) (year)

(c) Cemetery or crematory Moreland Memorial Park

Location Baltimore Md

18 (a) Funeral director Wm Cook

(b) Address 1217 St Paul St

19 (a) 9/12/40 (Date rec'd by registrar) (b) Milton M Wilson Local Deputy Registrar

W. McCarmine Reg. Dundalk, Md

MEDICAL CERTIFICATION

20. Date of death Sept. 12 1940, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19 1940, to 9-12 1940 and that I last saw ~~him~~ her alive on 9-12 1940.

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to From History — 3-4 yrs ??

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Helen G. Evans, M.D. (M. D. or other)

Address 55 Dundalk ave Date signed 9-12-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09399

Reg. Diat. No. 32

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Baltimore

City or town: Pikesville,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 50 years

Hospital, institution, or street address where death occurred:
8 Sudbrook Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8 Sudbrook Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary J. Randolph

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: ----------

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 26, 1860

8. AGE: Years	Months	Days	If less than one day
80	3	7	..... hrs. ..... min.

8. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: James T. Randolph

FATHER 13. Birthplace: ----- New Jersey

MOTHER 14. Maiden name: Mary Corrigan

MOTHER 15. Birthplace: Baltimore, Maryland

16. Informant: Miss Frances Corrigan

Address: 1303 Bolton St., Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/3/40 (month) (day) (year)

Cemetery or crematory: Holy Cross

Location: Harford Road, Baltimore

18. Funeral director: H W Wilson and Son

Address: 805 North Calvert Street

19. OCT 1 1940 (Date rec'd by registrar) E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 30th 1940, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 18th 1940, to Sept. 30th 1940 and that I last saw her alive on Sept. 27th 1940

	DURATION
Immediate cause of death: Angina Pectoris	1 day.
Due to: Art. Sclerosis	10 yrs.
Due to:	
Other conditions: Chronic Myocarditis	1 mon.

(Include pregnancy within 3 months of death)

Major findings of operations: .....Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James A. Miller M. D. M. D. or other

Address: Pikesville, Md. Date signed 10/1/40

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NOV 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

09400

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH (93-L)

County Baltimore Registration Dist. No. 30

Village or City Catonsville No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Charles D. Reaves If U. S. Veteran, specify WAR

(a) Residence: No. Ridgeway Road St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	W.	Widowed

5e. If married, widowed, or divorced HUSBAND of (or) WIFE of Late Amanda C. (Nee Heiser)

6. DATE OF BIRTH (month, day, and year) Mch. 1, 1850

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
90	6	25	

OCCUPATION

8. Trede, profession, or perticuler kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired

9. Industry or business in which work wes done, es SILK MILL, SAW MILL, BANK, etc. Farmer

10. Oete deceesed last worked et this occupetion (month end year)

11. Totel time (yeers) spent in this occupation

12. BIRTHPLACE (city or town) S. C. (State or country)

FATHER

13. NAME Reaves

14. BIRTHPLACE (city or town) S. C. (Stete or country)

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (Stete or country)

17. INFORMANT Mrs. W. Kenneth Van Sant

(Address) Ridgeway Rd. Catonsville

18. BURIAL, CREMATION, OR REMOVAL

Place Cedar Hill Date 9/30/40

19. UNDERTAKER Harry H. Mitzel

(Address) 4101 Edmondson ave

20. FILED 9-30 19 40 A. G. Andrear Registrar.

DEPUTY LOCAL

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Sept. (Month) 26, (Day) 1940. (Year)

22. I HEREBY CERTIFY, That I attended deceased from Dec 16, 1938, to Sept 26, 1940

I last saw h[illegible] alive on Sept 26, 1940; death is said to have occurred on the date stated above, at 3:35 P.M.

The **PRINCIPAL CAUSE OF DEATH** and releted causes of importance were es follows:

	Date of onset
Cardiac Vascular (Hemorrhage) (Stroke)	5 Years
Cerebral Hemorrhage	9/19/40

Other **Contributory Causes** of importence:

Neme of operation None Dete of

Whet test confirmed diegnosis? Physical Was there en autopsy? No

23. If deeth wes due to externel ceuses (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Dete of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or In PUBLIC PLACE.

Menner of Injury

Neture of injury

24. Wes diseese or injury in any wey reteted to occupation of deceased? No

If so, specify

(Signed) Elliott W. Dahlmon M. D.

(Address) 3432 Dudleigh ave

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

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Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

09401

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 3 mos., 26 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 3 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Mary's
City or town: Morganza
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3.(a) FULL NAME: Mrs. Mary G. Reeder

3.(b) Social Security Number: 577-22-0203

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: G. Stuart Reeder
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): June 20, 1890

8. AGE: Years	Months	Days	If less than one day
50	2	26	...hrs. ...min.

9. Birthplace: Hollywood, St. Mary's Co., Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home
FATHER 12. Name: John R. Garner
13. Birthplace: Hollywood, Maryland
MOTHER 14. Maiden name: Agnes Payne
15. Birthplace: Morganza, Maryland
16. Informant: Mrs. Mary G. Reeder
Address: Morganza, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 17, 1940 (month) (day) (year)
Cemetery or crematory: St. John's Cemetery
Location: Hollywood, Maryland
18. Funeral director: Jos. C. Mattingley
Address: Leonardtown, Maryland
19. Sept. 15 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 15, 1940, at 3:40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20, 1940, to Sept. 15, 1940 and that I last saw her alive on September 15, 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	17 yrs., 2 mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Mitral Stenosis	Unknown

(Include pregnancy within 3 months of death)
Major findings of operations: No operations
Date of op.
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Stewart L. Shaffer M.D.
M. D. or other
Address: Mt. Wilson, Md. Date signed: 9/15/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (115-c)

09402

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore

City or town Dundalk
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Colgate Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. North Point Road
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Claire Rhea Reinecke

3. (b) Social Security Number: ----------

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: ----------

6 (b) Name of husband or wife: ----------

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): January 11th. 1940

8. AGE: Years 0 | Months 7 | Days 23 | If less than one day ____ hrs. ____ min.

9. Birthplace: Baltimore Co. Maryland
(Town, county, and state)

10. Usual occupation: ----------

11. Industry or business: ----------

FATHER
12. Name: Robert F. Reinecke
13. Birthplace: Baltimore Co. Maryland

MOTHER
14. Maiden name: Martina Taylor
15. Birthplace: Baltimore Maryland

16. Informant: Robert F. Reinecke

Address: Dundalk Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 7th. 1940 (month) (day) (year)

Cemetery or crematory: Oak Lawn

Location: Baltimore Co Maryland

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Road

19. Sept. 5th 1940 (Date rec'd by registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 4th. 1940, at 2.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 7 1940, to Sept 4 1940 and that I last saw her alive on Sept 4 1940

Immediate cause of death	DURATION
Acute endocarditis	4 weeks
Due to Primary cause: Acute tonsillitis	
Due to C.W.G.R.	
Other conditions: Acute Bronchitis	One day

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: A Lee Hickey M. D. or other

Address: 4116 Northern Parkway Date signed: 9/5/40

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OCT 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1640)

09403

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County Balto.

City or town Dundalk.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 30 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto

City or town Dundalk Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1923 Dundalk Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Martha Richley

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Alexander Richley

6(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Dont Know

8. AGE: Years 45 | Months | Days | If less than one hrs. min.

9. Birthplace Austria (Town, county, and state)

10. Usual occupation At home

11. Industry or business

FATHER 12. Name Dont Know

13. Birthplace Austria

MOTHER 14. Maiden name Dont Know

15. Birthplace Austria

16. Informant Alex. Richley

Address 1923 Dundalk Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 21/1940 (month) (day) (year)

Cemetery or crematory Oak Lawn Cemetery

Location Baltimore Md

18. Funeral director John Ullrich

Address 2008 Orleans St

19. 9/20 1940 (Date rec'd by registrar) Milton M Brumlow Local Registrar Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18th 1940, at ? M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ~~19~~, to ~~19~~, and that I last saw h~~alive on~~ ~~19~~.

Immediate cause of death Suicide by hanging

Due to Deranged mind

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

~~Accident~~, suicide, ~~or homicide~~ Human Date of 9-18-1940

Where did injury occur? Dundalk (City or town) Balto (County) Md (State)

Injured at home, ~~farm, industry, public place (where?)~~ home

Means of injury hanging Injured at work? No

23. SIGNATURE W. P. E. Myse Lefty M Lex M. D. or other

Address Pikesville Md Date signed 9-19-40

W. M. Carmine Reg.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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OCT 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

09404

CERTIFICATE OF DEATH

Reg. Diat. No. 31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Randallstown (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Randallstown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Ethel R. Roach

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

8 (b) Name of husband or wife: Joseph L. Roach

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 24, 1896

8. AGE:

Years	Months	Days	If less than one day
44	6	2	hrs. min.

9. Birthplace: Balto Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER — 12. Name: Frank C. Atherton

FATHER — 13. Birthplace: Me.

MOTHER — 14. Maiden name: Thomasine Barber

MOTHER — 15. Birthplace: Md.

16. Informant: Joseph L. Roach

Address: Randallstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 29 1940 (month) (day) (year)

Cemetery or crematory: Mt. Olive Cemetery

Location: Randallstown Md.

18. Funeral director: C. Henry Esser

Address: Lyndeville Md.

19. Sept 27 1940 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1939, to Sept. 26 1940, and that I last saw h alive on Sept. 26, 1940

	DURATION
Immediate cause of death: Acute Dilatation of Heart	1 day
Due to: Valvular Heart Disease	25 yr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN — Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other

Address: Randallstown Date signed 9/26/40

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OCT 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 93d

Reg. Dist. No. 38

09405

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Rosedale (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rosedale (If outside city or town limits, write RURAL and give town)
(d) Street No. Ceiling Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Georgia Ida Ruth

3 (b) If veteran, name war ---

3 (c) Social Security No. ---

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Francis J. Ruth

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug. 1857

8. AGE: Years 83 | Months 1 | Days | If less than one day ____ hr. ____ min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation ____

11. Industry or business Housewife

FATHER
12. Name Geo. H. Landon
13. Birthplace Md.

MOTHER
14. Maiden Name Sophonia Ann Reeves
15. Birthplace Virginia

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1 1940 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 (a) 9/30/40 (Date rec'd by registrar) (b) A. M. Bacon Registrar

MEDICAL CERTIFICATION

20. Date of death Sept 29 1940, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1940, to Sept 29 1940, and that I last saw him alive on Sept 29 1940.

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular disease	
Due to	
Due to	
Other conditions Left Popliteal Thrombosis	1 wk

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J M Baumgardner M. D. or other

Address Reisterstown Md Date signed 9/29/40

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 5 1940
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

09406

CERTIFICATE OF DEATH

Reg. Diat. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 3 mos., 8 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 3 mos., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1710 Byrd Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: James D. Scheibe

3. (b) Social Security Number: 216-09-8624

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Frances Scheibe

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): November 12, 1904

8. AGE: Years	Months	Days	If less than one day
35	10	16	hrs. min.

9. Birthplace: Rehobeth, Somerset Co., Md.
(Town, county, and state)

10. Usual occupation: Policeman

11. Industry or business: Baltimore City Police Dept

FATHER
12. Name: Carl Scheibe
13. Birthplace: Germany

MOTHER
14. Maiden name: Texena Landon
15. Birthplace: Somerset Co., Maryland

16. Informant: James D. Scheibe

Address: 1710 Byrd St., Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 1, 1940 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Baltimore, Maryland

18. Funeral director: John J. Fahey & Sons,

Address: 1318 Light St., Baltimore, Md.

19. Sept. 28, 1940 (Date rec'd by registrar) J. Randolph Gresing Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 28, 1940 at 7:30A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20, 1940, to Sept. 28, 1940 and that I last saw him alive on September 28, 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 months
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Tuberculous Enteritis	6 months

(Include pregnancy within 3 months of death)

Major findings of operations: No operations

Date of op.:

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D.
M. D. or other

Address: Mt. Wilson, Md. Date signed: 9/28/40

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

09407

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County Balto
City or town Towson
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 527 YORK ROAD
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 19 YRS.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County BALTO.
City or town TOWSON Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 529 YORK ROAD
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR WORLD WAR

3. (a) FULL NAME Jim Stanley Schnaufer (SCHNAUFER)

3. (b) Social Security Number

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Emma Louise Schnaufer (OTTO)
6(c) If alive, give age ——— years
7. Birth date of deceased (mo., day, yr.) April 17, 1889

8. AGE: Years 51 | Months 5 | Days 1 | If less than one day ___ hrs. ___ min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation Merchant
11. Industry or business Self

FATHER
12. Name Frederick W. Schnaufer
13. Birthplace Germany

MOTHER
14. Maiden name Catherine S. Schnaufer
15. Birthplace Germany

16. Informant J. Rollin Otto,
Address Ruxton, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof SEPT. 21, 1940 (month) (day) (year)
Cemetery or crematory GREENMOUNT CEM.
Location BALTIMORE, MD.
18. Funeral director John Burns' Sons
Address Towson, Md.

19. 9/21 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18th 1940 4-20 PM

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ~~19 to 19~~, ~~and that I last saw h alive on 19~~.

Immediate cause of death — DURATION

Due to Coronary thrombosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy No

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. T. E. Nyse Lucy M. Cox M. D. or other
Address Pikesville Md. Date signed 9-18-40

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

09408

Reg. Dist. No. 29

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Monkton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town My Lady's Manor Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Monkton, R. D.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No.

3. (a) FULL NAME Frank Michal Schmidt

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Christine Brunne

6(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1871

8. AGE: Years	Months	Days	If less than one day
68	~~9~~ 9	15	hrs. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual occupation Blacksmith

11. Industry or business

FATHER 12. Name Chas Schmidt

13. Birthplace Germany

MOTHER 14. Maiden name Barbara Hoffman

15. Birthplace Germany

16. Informant Mrs Frank M. Schmidt

Address Monkton, Maryland

17. ~~St Dances~~ Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 11, 1940 (month) (day) (year)

Cemetery or crematory St James

Location My Lady's Manor Monkton, Md.

18. Funeral director Landon M. Bunting

Address Sparks, Md.

19. Sept 9 1940 (Date rec'd by registrar) Anna Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1940, at 12 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 8 1940, to Sept 8 1940

and that I last saw him alive on 9/8/40 19

Immediate cause of death	DURATION
CORONARY THROMBOSIS	1 HOUR
Due to ARTERIOSCLEROTIC	
CARDIO VASCULAR DISEASE	10 YRS.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George Schmidt M. D. or other

Address Carlsville, Md. Date signed 9/8/40

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

09409

CERTIFICATE OF DEATH

Reg. Dist. No. 43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Carney
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Carney Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: East Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Henry Schulte

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife: Kunigunda Schulte
6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 9th. 1859

8. AGE: Years	Months	Days	If less than one day
81	4	10	____ hrs. ____ min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Butcher
11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Joseph Schulte
Address: East Ave. Carney

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/22/40 (month) (day) (year)
Cemetery or crematory: St. Johns Lutheran
Location: Balto. Co. Maryland

16. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Road

19. 9/20 1940 (Date rec'd by registrar) Mrs G. A. Fritz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19 1940, at 9:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6 1940 to September 19 1940 and that I last saw him alive on September 19 1940.

Immediate cause of death	DURATION
Coronary Thrombosis	Sept 19/40
Due to	
Due to	
Other conditions: Chronic Myocarditis (Include pregnancy within 3 months of death)	A number of years.

Major findings:
Of operations: ✓
Of autopsy: ✓

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ✓ Date of: ✓
Where did injury occur? ✓ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ✓
Means of injury: ✓ Injured at work? ✓

23. SIGNATURE: Morris B. Green M.D. M. D. or other
Address: 3009 Evergreen Ave Baltimore Md. Date signed: Sept 20/40

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

09410

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:
County Baltimore
City or town Fullerton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Belair Rd. near Necker Ave.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Fullerton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Belair Rd. nr. Necker Ave.,
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME JOHN SEIFRIED

3. (b) Social Security Number ***

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife --
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 15th, 1877

8. AGE: Years	Months	Days	If less than one day
62	10	26	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Truck Farmer
11. Industry or business
FATHER 12. Name George Seifried
13. Birthplace Germany
MOTHER 14. Maiden name Unknown
15. Birthplace Germany
18. Informant Mr. George Seifried
Address Fullerton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 14, 1940 (month) (day) (year)
Cemetery or crematory St. Josephs Cemetery
Location Fullerton, Md.
18. Funeral director Lansdale Funeral Home
Address 7401 Belair Road
19. 9/13 1940 Mrs. G. A. Fritz
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11th 1940, at 7:05 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1939, to Sept. 11th 1940,
and that I last saw him alive on Sept. 11th 1940 19

Immediate cause of death	DURATION
Acute myocarditis	3 weeks.
Mitral regurgitation	1 year.
Due to Oedma of lungs.	In two-
Chronic interstitial nephritis	6
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert G Webster M.D.
M. D. or other
Address 6409 Belair Road Date signed 8-12-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

09411

Reg. Diat. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 0 mos., 18 days
Hospital, Institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 1 yr., 0 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1405 Waterview Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Sharretts

3.(b) Social Security Number: 218-10-4723

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mrs. Jessie Sharretts
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 28, 1876

8. AGE: Years	Months	Days	If less than one day
63	10	14	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Watchman
11. Industry or business: Unknown

FATHER
12. Name: Samuel F. Sharretts
13. Birthplace: Maryland

MOTHER
14. Maiden name: Amanda Watkins
15. Birthplace: Howard County, Maryland

16. Informant: William Sharretts
Address: 405 Waterview Ave., Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 13, 1940 (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Maryland

18. Funeral director: Charles F. Evans & Son
Address: 118 W. Mt. Royal Ave., Baltimore, Md.

19. Sept. 11, 1940 (Date rec'd by registrar) J. Frank Spalding Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11, 1940 at 6:35A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 24, 1939, to September 11, 1940
and that I last saw him alive on September 11, 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 2 yrs., 1 mo.
Due to: Tubercle Bacilli
Due to:
Other conditions: None
(Include pregnancy within 3 months of death)

Major findings of operations: No operations
Date of op.:
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D.
M.D. or other
Address: Mt. Wilson, Md. Date signed: 9/11/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-B)

09412

CERTIFICATE OF DEATH

Reg. Dist. No. 5 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore,

City or town: Fudowood Sanatorium, Towson, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days): 7 years 12 days

Stay in this community (yrs., or mos., or days): Sawr

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Randalls Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: ?
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No.

3. (a) FULL NAME: Moses Adolph Smith

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

8 (b) Name of husband or wife: (?)

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): February 7, 1861

8. AGE:

Years	Months	Days	If less than one day
79	6	25	____ hrs. ____ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Gardener

11. Industry or business: Private Home.

FATHER
12. Name: Thomas E. Smith
13. Birthplace: Fremont County, Md.

MOTHER
14. Maiden name: Susan J. Hull
15. Birthplace: Virginia.

16. Informant: Personal History - Hospital Records

Address: Fudowood Sanatorium, Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 3 40 (month) (day) (year)

Cemetery or crematory: St. Johns Cemetery

Location: Ellicott City, Md

18. Funeral director: Stewart & Mowen Co.

Address: 108-W-North Ave.

19. Sept 1 (Date rec'd by registrar) 19 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1, 1940, at 7:20 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 11 1933 to September 1 1940 and that I last saw him alive on September 1 1940

Immediate cause of death	DURATION
Carcinoma of Prostate	Aug 1939
Due to	
Due to	
Other conditions	
Pulmonary Tuberculosis, arrested (Include pregnancy within 3 months of death)	1897

Major findings:

Of operations:

Of autopsy: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: W A Bridges M. D. or other

Address: Towson, Md. Date signed 9-1-40

Correction of middle name: Burial permit presented and retained by undertaker Sep 5 1940 in this Bureau. - L

STATE OF MARYLAND—CERTIFICATE OF DEATH

09413

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH (46R)

County Baltimore — Registration Dist. No. 38

Village or City Catonsville — No. Putty Hill & Victory Ave St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S. If of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Selena B. Smith — If U. S. Veteran, specify WAR ____

(a) Residence: No. Putty Hill & Victory Ave St., Ward. ____

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F.	W	widow

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: Jacob L.

6. DATE OF BIRTH (month, day, and year): Mar 1 - 1857

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	83	6	7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: At Home

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: X

10. Date deceased last worked at this occupation (month and year): ____

11. Total time (years) spent in this occupation: ____

12. BIRTHPLACE (city or town) (State or country): Md

FATHER

13. NAME: Isaac Merchey

14. BIRTHPLACE (city or town) (State or country): Pa

MOTHER

15. MAIDEN NAME: Caroline Peak

16. BIRTHPLACE (city or town) (State or country): ✓

17. INFORMANT: Louis S. Smith

(Address) Putty Hill & Victory Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Leister Cem Westminster Md — Date 9-10, 1940

19. UNDERTAKER: Howard J. Buck

(Address) 5305 Harford Rd

20. FILED 9/10, 1940 A. M. Bacon

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Sept (Month) 8 (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Aug 1, 19xx, to 9/8, 19xx.

I last saw her alive on 9/8, 19xx; death is said to have occurred on the date stated above, at 7.50 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Carcinoma of Stomach	

Other Contributory Causes of Importance:

Name of operation ____ Date of ____

What test confirmed diagnosis? Clinical — Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of Injury ____, 19____

Where did Injury occur? ____ (Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury ____

Nature of Injury ____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify ____

(Signed) Wm W Jolley M. D.

(Address) 5703 Harford Rd.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-C)

09414

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3027 Brighton Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME FRANKLIN
Addison Smoot

3. (b) Social Security Number 716-12-3609

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Virginia Disney

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 13, 1879

8. AGE: Years	Months	Days	If less than one day
60	11	12	hrs. min.

9. Birthplace: Richmond County, Virginia
(Town, county, and state)

10. Usual occupation: Freight conductor

11. Industry or business: Pennsylvania R.R.

FATHER
12. Name: Benjamin B. Smoot
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Jane Balderson
15. Birthplace: Virginia

18. Informant: MARY JANE SMOOT Hospital records

Address: 3027 BRIGHTON ST

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: 9-27-40 (month) (day) (year)

Cemetery or crematory: LOUDON PARK

Location: BALTIMORE CITY

18. Funeral director: WM J TICKNER & SONS

Address: NORTH & Pennsylvania Ave

19. 9/25/40 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 25, 1940, at 4:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 23, 1940, to September 25, 1940 and that I last saw him alive on September 25, 1940

Immediate cause of death	DURATION
Carcinoma of left bronchus with metastes of the mediastinum, the liver, spleen and superarenal glands.	before 1940
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: As given above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Serge Androp
Serge Androp, M.D. M. D. or other

Address: Spring Grove St. Hosp. Date signed: 9-25-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 28 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

09415

CERTIFICATE OF DEATH

Reg. Dist. No. 43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Fullerton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: East Joppa Road
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 26 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Fullerton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: East Joppa Road
(If rural give LOCATION)
2(a) IF YETERAN, NAME WAR:

3. (a) FULL NAME: MARGARET C. SOMMER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Henry W. Sommer
6(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): March 20, 1875

8. AGE: Years	Months	Days	If less than one day
65	5	21	hrs. min.

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: John Ulrich
13. Birthplace: Germany
MOTHER 14. Maiden name: - Herget
15. Birthplace: Germany
16. Informant: Mr. Henry W. Sommer
Address: East Joppa Rd., Fullerton
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 14, 1940 (month) (day) (year)
Cemetery or crematory: Moreland Memorial Park
Location: Taylor Ave.
18. Funeral director: Lauchheimer Funeral Home
Address: 7401 Belair Road
19. 9/13 (Date rec'd by registrar) 19 40 Mrs G.A. Fritz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11th 1940, at 5:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/11 19 40 to 9/11 19 40, and that I last saw h[illegible] alive on 9/11/ 19 40.

Immediate cause of death	DURATION
Coronary Artery Thrombosis	1 hour
Due to Coronary Arteriosclerosis	unknown
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John A Drachen M.D. M. D. or other
Address: 6304 Belair Rd. Baltimore, Md. Date signed 9/12/40

RECEIVED
SEP 18 1940
BUREAU V. S.

09416

STATE OF MARYLAND
CERTIFICATE OF DEATH

48-a

Registration Dist. No. 31

[1] PLACE OF DEATH

County Balto

Village or ~~City~~ Woodlawn (No. Gwynn Oak Ave Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

[2] FULL NAME Clara Martha Stine

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED~~ (Write the word)

6 DATE OF BIRTH: April (Month) 26 (Day), 1860 (Year)

7 AGE: 80 yrs. 4 mos. 29 ds. If LESS than 1 day ✓ hrs. or ___ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed or (employer): None

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Jacob Mullendore

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Gloss

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Daisy Walters

(Address) Trego. Md

15 Filed Sept 25 1940 Henry A. Owings Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: ___, 192___
September (Month) 25 (Day) 1940 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 30 1940 to Sept 25, 1940, that I last saw her alive on Sept 25, 1940, and that death occurred on the date stated above, at 2:10 P m.

The CAUSE OF DEATH * was as follows:

Carcinoma of Cervix

(Duration) ___ yrs. 3 mos. ___ ds.

Contributory Secondary: Cerebral Hemorrhage

(Duration) ___ yrs. ___ mos. 2 ds.

(Signed) Geo. P. Everhart M. D.

Sept 25 1940 (Address) 5100 Windsor Mill Rd Balto

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Rohersville Md

DATE OF BURIAL: Sept 29, 1940

20 UNDERTAKER: William F Bast & Son

ADDRESS: Boonsboro Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesmon,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager." "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sorcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia,*" "PUERPERAL *peritonitis,*" *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 3 1909

09417

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Balto.

City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 yrs

Hospital, institution, or street address where death occurred: 634 Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: G. Walter Tovell

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mamie E. Tovell

B.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Feb. 26, 1876

8. AGE: Years: 64 Months: 6 Days: 23 If less than one day: hrs. min.

9. Birthplace: Balto. City
(Town, county, and state)

10. Usual occupation: Contractor & Builder

11. Industry or business

FATHER
12. Name: Robert R. Tovell
13. Birthplace: Balto. Co.

MOTHER
14. Maiden name: Catherine Griffin
15. Birthplace: Balto. Co.

16. Informant: C. Eugene Tovell
Address: Reisterstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 21, 1940 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Balto. Co.

18. Funeral director: J. F. Eline & Sons
Address: Reisterstown, Md.

19. Sept. 19 1940 (Date rec'd by registrar) J. [illegible] MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 18th 1940, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15th 1940, to Sept 18th 1940 and that I last saw him alive on Sept 18th 1940

Immediate cause of death: Cerebral Hemorrhage — DURATION: 3 hr

Due to: Arterio Sclerosis — 5 yrs

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. [illegible] MD M. D. or other

Address: Reisterstown Date signed: [illegible]

VS A15 (T) (I) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 2 1940
BUREAU V.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

09418

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH: Balto

County

City or town Glenn Arm

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Glenarm Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Sunshine Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Frank Trout

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 70 | Months | Days | If less than one day hrs. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER

12. Name Michael Trout

13. Birthplace [illegible]

MOTHER

14. Maiden name Jemima Davis

15. Birthplace Pennsylvania

16. Informant

Address [illegible]

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-22-1940 (month) (day) (year)

Cemetery or crematory Zion Cemetery

Location Hopewell Township Pennsylvania

18. Funeral director Lassahn Funeral Homes

Address

19. 9/22 1940 (Date rec'd by registrar) Mrs. G. A. Fritz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1940, at 8.40 PM

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ~~19 to 19~~ ~~and that I last saw h alive on 19~~

Immediate cause of death Auto Accident on

Due to highway

Due to Multiple fractures of skull

Other conditions and other injuries

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy No

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~ Accident Date of 9-21-40

Where did injury occur? Glenn Arm (City or town) Balto (County) Md (State)

Injured at ~~home, farm, industry~~, public place (where?) highway

Means of injury Auto Accident Injured at work? No

23. SIGNATURE W. P. O. Myse Supy M Ex M. D. or other

Address Pleasville Md Date signed 9-21-40

RECEIVED
OCT 2 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

09419

(131-a)

1. PLACE OF DEATH

County Baltimore Registration Dist. No. 42

Village or City Lansdowne No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? 53 yrs. mos. ds.

2. FULL NAME George Waldmann

(a) Residence: No. Walnut Ave St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena Waldmann

6. DATE OF BIRTH (month, day, and year): Jan. 23. 1870

7. AGE: Years 70 Months 7 Days 11 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Blacksmith

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Balto Transit Co

10. Date deceased last worked at this occupation (month and year): Apr 1939.

11. Total time (years) spent in this occupation: 45 yrs

12. BIRTHPLACE (city or town) (State or country): Germany.

FATHER

13. NAME: John Waldmann

14. BIRTHPLACE (city or town) (State or country): Germany

MOTHER

15. MAIDEN NAME: Catherine Günther

16. BIRTHPLACE (city or town) (State or country): Germany.

17. INFORMANT (Address): Lena Waldmann, Walnut Ave. Lansdowne

18. BURIAL, ~~CREMATION, OR REMOVAL~~ Place: Western Date: Sept 6., 1940

19. UNDERTAKER (Address): Mr. Mrs. John W. Geufel & Son, 801 W Fayette St

20. FILED: Sept 4, 1940 Geo Kieffer Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Sept. (Month) 3 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Aug 19, 1940, to Sept 3, 1940

I last saw him alive on Sept 3, 1940; death is said to have occurred on the date stated above, at 1:45 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cardio vascular	?
renal disease	?

Other Contributory Causes of importance:

Cerebral haemorrhage	
mid right side	2 wks
hemiplegia	

Name of operation: no Date of

What test confirmed diagnosis? Examinata Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Geo Kieffer M.D.

(Address) 2470 Wash Blvd

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

RECEIVED SEP 7 1927 BUREAU OF

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

09420

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore County

City or town: Woodbrook
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Haddon Ave

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 21 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Woodbrook Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Haddon & Bellona Aves
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Emma F. D. Whitney

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	white	married

6 (b) Name of husband or wife: William Whitney

6(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Aug 9th 1886

8. AGE:

Years	Months	Days	If less than one day
54	0	28	hrs. min.

9. Birthplace: Rutherford North Carolina
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: George Mack Freeman
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Mary Elizabeth Lane
15. Birthplace: North Carolina

16. Informant: Etta Whitney daughter

Address: Woodbrook Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 9th 1940 (month) (day) (year)

Cemetery or crematory: Bloreland Park

Location: Baltimore Co Md

16. Funeral director: William Cook

Address: 1217 N Paul St Baltimore Md

18. Sept 8 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 7th 1940, at 3:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 4th 1939, to Sept 7th 1940, and that I last saw h[illegible] alive on Sept 6th 1940.

Immediate cause of death: Generalized Carcinoma

Due to: Cancer of breast

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Dt operations: Amputation right breast; amputation right arm

Dt autopsy:

DURATION: 8 yrs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R Walter Graham Jr MD
M. D. or other

Address: 700 Cathedral St Baltimore Date signed: 9/7/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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SEP 24 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

09421

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County Baltimore
City or town Randallstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Liberty Road.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 35 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Randallstown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Liberty Road.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Beverly W. Widerman

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Sarah E. Colson Widerman
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 3, 1858

8. AGE: Years 82 | Months 2 | Days 18 | If less than one day ____ hrs. ____ min.

9. Birthplace: Maryland. (Town, county, and state)
10. Usual occupation: Farmer Retired
11. Industry or business
12. FATHER — Name: George Widerman
13. FATHER — Birthplace: Maryland.
14. MOTHER — Maiden name: Arsenath Appley
15. MOTHER — Birthplace: Maryland.
16. Informant: Mrs. Walter F. Sanley
Address: Randallstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 24, 1940 (month) (day) (year)
Cemetery or crematory: Mt. View Cem.,
Location: Alpha Howard Co.
18. Funeral director: Easton Sons
Address: Ellicott City
19. Sept 24 1940 (Date rec'd by registrar) Wm E Martin Registrar

MEDICAL CERTIFICATION A,

20. DATE OF DEATH: Sept. 21 1940, at 510 M

I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1940, to Sept 21 1940
and that I last saw h~~e~~ alive on Sept 20 1940

Immediate cause of death	DURATION
Generalized Arteriosclerosis	6 years
with Myocardial Renal failure	-
Due to	
Due to	
Other conditions: Secondary Anemia	
Chr. Prostatic Hypertrophy	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thos. J Abbott M. D. or other
Address 4509 Liberty Heights Ave Date signed Sept 23rd

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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OCT 3 1940
BUREAU V. S.

09422

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore

City or town Stevenson (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Baltimore

City or town Stevenson (If outside city or town limits, write RURAL and give nearest town)

Street No. Old Valley Rd. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Carrie Lincoln Windsor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Dr. Samuel J. Windsor

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 26 1865

8. AGE: Years	Months	Days	If less than one day
75	7	11	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Henry Shane

13. Birthplace Phila. Pa.

MOTHER 14. Maiden name Virginia Evans

15. Birthplace Deal's Island, Som. Co

16. Informant Mr. Samuel Windsor (Son)

Address 1903 Mosher St. Baltimore, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 10 1940 (month) (day) (year)

Cemetery or crematory Druid Ridge

Location Pikesville Md.

18. Funeral director William J. Tickner & Sons

Address North & Pennsylvania Aves

19. Sept 9 1940 (Date rec'd by registrar) E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1940, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 1940, to Sep 7 1940 and that I last saw her alive on Sep 7 1940

Immediate cause of death	DURATION
Cerebral hemorrhage	2 wks
Due to Arteriosclerosis	?
Hypertension	?
Due to	
Other conditions Bronchial Pneumonia (Include pregnancy within 3 months of death)	

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

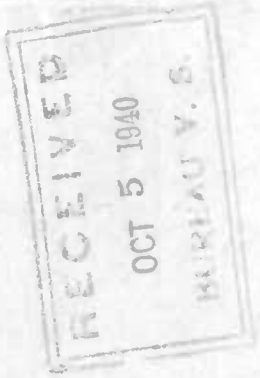
23. SIGNATURE Samuel H Culver Md M. D. or other

Address 5611 Pimlico Rd Date signed Sep. 9-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Culver
5611 Pimlico Rd.



STATE OF MARYLAND—CERTIFICATE OF DEATH

09423

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH (46-D)

County Balto. Registration Dist. No. 44

Village or City Bowleys Quarters No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Charles George Wolff If U. S. Veteran, specify WAR

(a) Residence: No. Bowleys Quarters St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M.	W.	married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Isabella York

6. DATE OF BIRTH (month, day, and year) Oct. 9-1868

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	11	8	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Farmer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Harford Co. (State or country)

FATHER

13. NAME Chas. G. Wolff

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Mary Unk.

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT Wife (Address) Bowleys Quarters

18. BURIAL, CREMATION, OR REMOVAL Place Ebenezer Cem. Date Sept. 20, 1940

19. UNDERTAKER John G. Connelly (Address) Essex, Md.

20. FILED Sept. 20, 1940 John G. Connelly Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH ~~Sept.~~ August 17 (Month) (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from August 15, 1940 to ~~August~~ August 17, 1940

I last saw him alive on ~~August~~ August 17, 1940; death is said to have occurred on the date stated above, at 4 50 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Carcinoma of the rectum	1939
Intestinal obstruction -	9/10/40

Other Contributory Causes of importance:

Name of operation Date of

What test confirmed diagnosis? X-ray Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) George A. Lawyer M. D.

(Address) Essex, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (120-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

09424

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 16 Hustings Ave

Stay in hospital or inst. (yrs., or mos., or days) 4 mo

Stay in this community (yrs., or mos., or days) ?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore

City or town Baltimore Md

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1103 E 22nd St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME Florence G Wright

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: David G Wright

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec 23 1876

8. AGE: Years 63 | Months 8 | Days 12 | If less than one day ____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Daniel W Ditch

13. Birthplace: Pa

MOTHER

14. Maiden name: Rebecca J Baker

15. Birthplace: Pa

16. Informant: Carrie P Kay

Address: 16 Hustings Ave

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Sept 7 1940 (month) (day) (year)

Cemetery or crematory: London Park

Location: Baltimore Md

18. Funeral director: William Cook

Address: 1217 St Paul St

19. 9/5 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 5 1940, at 6a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 1935, to Sep. 5 1940, and that I last saw her alive on Sept. 1 1940.

Immediate cause of death: Ulcerative cocitis

Due to

Due to

Other conditions: none

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 6 yrs

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Edward Novak M.D. M. D. or other

Address: 101 W. Read St Date signed Sep 5. 40

VS A15 (I) (T) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 18 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(107)

09425

CERTIFICATE OF DEATH

Reg. Dist. No. 48

1. PLACE OF DEATH:

County Baltimore

City or town Kenwood (Overlea)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 14 Glenmore Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Kenwood (Overlea) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 14 Glenmore Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME Margaret Zabel

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Charles H. A. Zabel

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb. 28th. 1854

8. AGE: Years	Months	Days	If less than one day
86	6	14	____ hrs. ____ min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name John Schwarz
13. Birthplace Germany

MOTHER
14. Maiden name Unknown
15. Birthplace Germany

16. Informant Henry Zabel

Address 12 Glenmore Ave. Overlea

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 16th. 40 (month) (day) (year)

Cemetery or crematory Mt. Carmel Cemetery

Location Baltimore Maryland

18. Funeral director Lassahn Funeral Home

Address 7401 Belair Road

19. 9/14 1940 (Date rec'd by registrar) Mrs. G. A. Fritz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12th. 1940, 10.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1st 1940, to Sept. 12th 1940, and that I last saw her alive on September 12th 1940.

Immediate cause of death Hypostatic pneumonia arteria sclerosis. Infirmities of age.

Due to Bronchopneumonia. Duration: three days. C.W.G.R.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations No

Of autopsy No

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. ~~or other~~

Address 3005 St. Paul St. Date signed Sept. 14th/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 2 1940
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